

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04522

CERTIFICATE OF DEATH

04523

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gambrills</u>		b. COUNTY <u>Anne Arundel</u>	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gambrills</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 448</u>		d. STREET ADDRESS <u>Box 448</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <u>Eugene</u>	Middle <u>Aisquith</u>	4. DATE OF DEATH Month <u>4</u> Day <u>4</u> Year <u>1967</u>
S. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 6, 1903</u>
9. AGE (In years lost birthday) yrs. <u>63</u>	10. KIND OF BUSINESS OR INDUSTRY <u>County Road Construction</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Lothian</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>James Aisquith</u>	14. MOTHER'S MAIDEN NAME <u>Sally Brady</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>213-28-0573</u>	17. INFORMANT <u>daughter: Mrs. Roberta Rieken - same as #2 above</u>	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Emphysema</u> DUE TO <u>5271</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>+ Fibrosis</u> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1959</u> to <u>4-4-67</u> , that (I) (we) last saw the deceased alive on <u>4-1-67</u> , and that death occurred at <u>37A M</u> , from cause _____ and on the date stated above.			
22a. SIGNATURE <u>F.M. Stimpsey</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>F.M. Stimpsey</u>	22d. ADDRESS <u>Cathedral St., Annapolis, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>April 6, 1967</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Mt. Zion Methodist Ch. Cem. Lothian</u>	23d. LOCATION (City or Town) (County) (State) <u>Anne Arundel, Md.</u>
24. FUNERAL DIRECTOR <u>Beverley E. Hopping</u>	ADDRESS <u>Beverley E. Hopping</u>	25a. REC'D BY REGISTRAR <u>APR 7 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
HOPPING FUNERAL HOME - Annapolis, Md.			

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

04523

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04524

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and bury event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>A.A.CO</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>A.A.CO</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis - MD</i>		c. LENGTH OF STAY IN lb d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis - MD</i>	
c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>D.O.A - Annie ARUNOEL - general</i>		d. STREET ADDRESS <i>Box 403-Rt 4-Cape St Clare</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>FRANK</i>		First <i>F</i>	Middle <i>A</i>
Last <i>Albert</i>		4. DATE OF DEATH <i>4 26 1967</i>	Month Day Year
S. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-29-59</i>
9. AGE (In years lost birthday) <i>67 yrs.</i>		10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore City Police Baltimore, Maryland</i>	
13. FATHER'S NAME <i>John Albert</i>		14. MOTHER'S MAIDEN NAME <i>Josephine Rohleder</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-26-1672</i>	
17. INFORMANT <i>Mrs Anna M. Albert, Box 403, Rt. 4, Cape St.</i>		Address <i>Clare</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertension Q.V. disease</i> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>hours</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>E.H. Edwards</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	
EXAMINER'S NAME (Type) <i>E.H. Edwards</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i>Baltimore, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4-29-1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Holy Redeemer</i>
23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <i>Lilly &amp; Zeiler Inc. 1901-07 Eastern Ave.</i>		25a. REC'D BY REGISTRAR ADDRESS	25b. REGISTRAR'S SIGNATURE DATE APR 27 1987 <i>J. Charles Judge</i>

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04524

CERTIFICATE OF DEATH

04525

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>9 hours</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Frederick Arthur AMSTER</b>		4. DATE OF DEATH Month <b>April</b> Doy <b>22</b> Year <b>1967</b>	
5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b>		7. MARRIED NEVER MARRIED <input type="checkbox"/> MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 18, 1899</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Art Dir.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Star Newspaper</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Rhode Island</b>
13. FATHER'S NAME <b>Fritz Amster</b>		14. MOTHER'S MAIDEN NAME <b>Anna ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-10-2420</b>	17. INFORMANT <b>Mr. Richard F. Amster - Hill Rd., Mt. Rainier, Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>33IX</b>		(Son) INTERVAL BETWEEN ONSET AND DEATH <b>Cerebral hemorrhage</b> <b>2 days</b>	
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause (b)		DUE TO <b>Hypertensive vascular Disease</b>	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Doy, Year Hour : o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) <b>Robert O'Brien</b> attended the deceased from <b>4/22</b> , 19 <b>67</b> , to <b>April 22</b> , 19 <b>67</b> , that (I) <b>Robert O'Brien</b> last saw the deceased alive on <b>4/22</b> , 19 <b>67</b> , and that death occurred at <b>Robert O'Brien</b> , M, from causes and on the date stated above.			
22a. SIGNATURE <b>Robert O'Brien</b>		12:35 am	22b. DATE SIGNED <b>4/22/67</b>
22c. PHYSICIAN'S NAME (Type) <b>Robert O'Brien</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/24/67</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Fort Lincoln Cemetery</b>
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04525

## CERTIFICATE OF DEATH

04526

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millersville</b>		c. LENGTH OF STAY IN lb <b>1 month</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Knollwood Manor Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Clara Gertrude ANDERSON</b>		First	Middle	
4. DATE OF DEATH <b>April 16</b>	Month	Day	Year <b>1967</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>negro</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	
8. DIVORCED <input type="checkbox"/>		9. DATE OF BIRTH <b>3-28-1900</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Matthew T. Anderson</b>		14. MOTHER'S MAIDEN NAME <b>Mary C. Staubus</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-38-9422</b>		
17. INFORMANT <b>(Son) Grafton Johnson, same address</b>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b>		<b>6 months</b>		
4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Hypertensive cardiovascular disease</b>		<b>several years</b>		
(c) DUE TO -----		-----		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <b>Arteriosclerosis (general, coronary and cerebral) Chronic pyelonephritis, Uremia</b>				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		
		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>March 2, 1967</b> , to <b>April 16, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 10, 1967</b> , and that death occurred at <b>12:40 p.m.</b> from causes and on the date stated above.		22b. DATE SIGNED <b>April 17, 1967</b>		
22c. PHYSICIAN'S NAME (Type) <b>Charles W. Kinzer, M. D.</b>		22d. ADDRESS <b>South River Medical Center Edgewater, Maryland 21037</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial 4-19-1967</b>		23b. DATE THEREOF <b>4-19-1967</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Broadneck</b>	
24. FUNERAL DIRECTOR <b>William Beeson, Cremation M.</b>		ADDRESS	23d. LOCATION (City or Town) (County) (State) <b>St. Margaret's Rd.</b>	
		25a. REC'D BY REGISTRAR <b>APR 17 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04526

## CERTIFICATE OF DEATH

04527

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

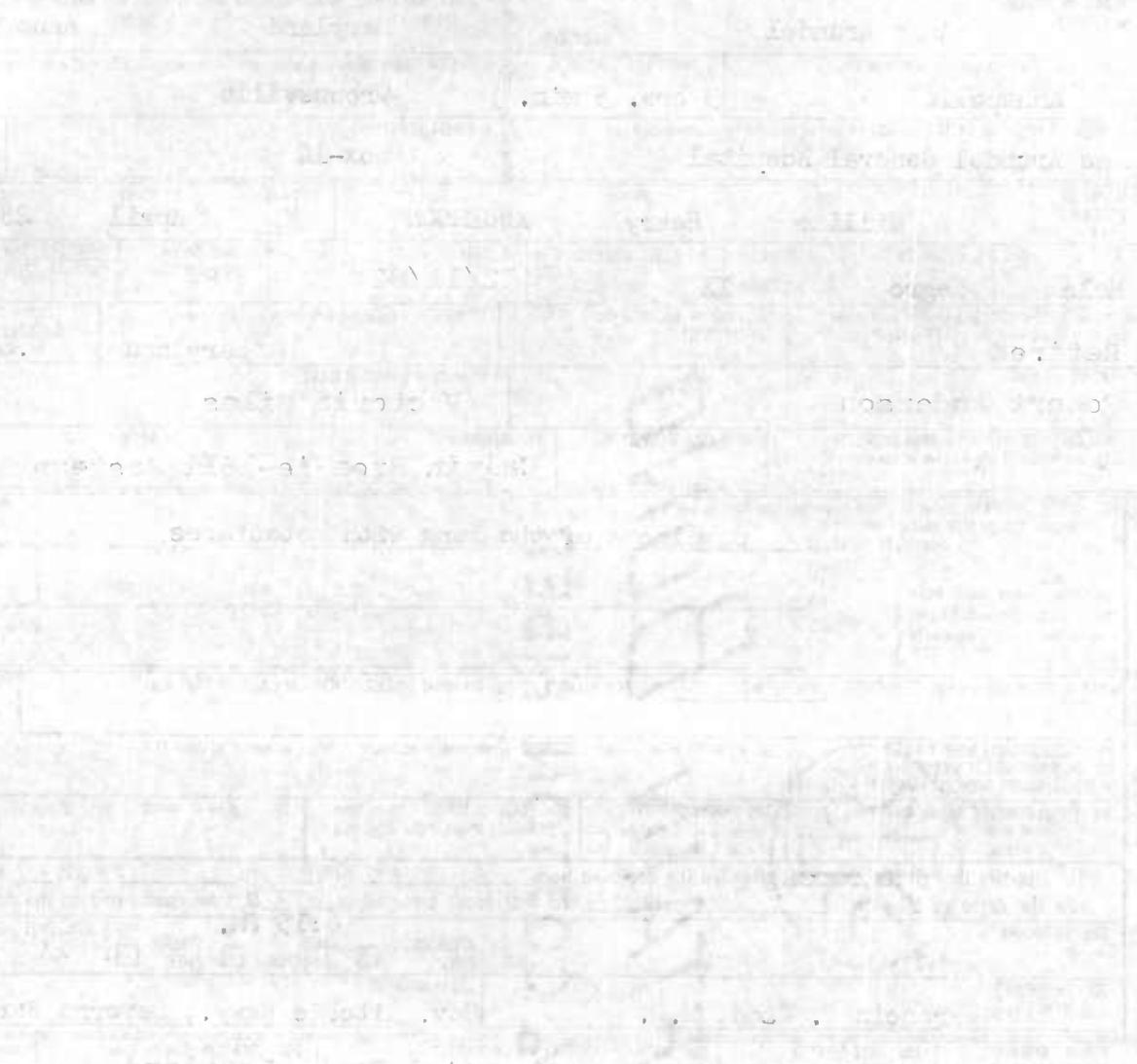
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY  Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 3 hrs. 5 min.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Box-14	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First William	Middle Henry	Last ANDERSON
4. DATE OF DEATH	Month April	Doy 26	Year 1967
S. SEX Male	6. COLOR OR RACE Negro	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 12/11/82	9. AGE (In years lost birthday) 84 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Doy 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Robert Anderson	14. MOTHER'S MAIDEN NAME Victoria Giles	Address Calvin Broadis-1611 Eastern Ave., N.E.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), (b) stating the underlying cause DUE TO lost. (c)			
INTERVAL BETWEEN ONSET AND DEATH 4 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) attended the deceased from 4-26, 1967, to 4-26, 1967, that (I) last saw the deceased alive on 4-26, 1967, and that death occurred at M, from causes and on the date stated above.			
22a. SIGNATURE Francis I. Codd	6:15 PM.	22b. DATE SIGNED 4-27-67	
22c. PHYSICIAN'S NAME (Type) Francis I. Codd, M.D.	22d. ADDRESS Gov. Ritchie Hwy., Severna Park, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/1/67	23c. NAME OF CEMETERY OR CREMATORIALY Harmony Memorial Park	23d. LOCATION (City or Town) Maryland (County) (State)
24. FUNERAL DIRECTOR Stewart Funeral Home	ADDRESS 4001 Benning Rd., N.E.	25a. REC'D BY REGISTRAR MAY 1 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04527

CERTIFICATE OF DEATH

04528

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 2 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Anne Arundel</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Annapolis Nsg. &amp; Convalescent Center</i>		d. STREET ADDRESS <i>1030 Boucher Ave.</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <i>BERTITA</i>	Middle <i>B</i>	4. DATE OF DEATH Month <i>April</i> Day <i>28</i> Year <i>1967</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>Caucasian</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-29-1884</i>	
9. AGE (In years lost birthday) <i>82 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Anne Arundel, Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>FRED RAST</i>	14. MOTHER'S MAIDEN NAME <i>EMMA PHILLIPS</i>	Address		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>	16. SOCIAL SECURITY NO. <i>214-05-0438</i>	17. INFORMANT <i>Mrs. CHARLES FITWELL</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Artherosclerotic Heart Disease</i> DUE TO <i>Hypertension</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Arterial Hypertension</i> (c) DUE TO <i>Hemiplegia</i>	INTERVAL BETWEEN ONSET AND DEATH <i>-</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Annapolis</i>	(County) <i>Anne Arundel</i> (State) <i>Md.</i>
21. I certify that (I) (this hospital) attended the deceased from <i>26 July</i> , 19 <i>67</i> , to <i>4-28</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>4-26</i> , 19 <i>67</i> , and that death occurred at <i>2:30 P.M.</i> from causes and on the date stated above.	22b. DATE SIGNED <i>4-29-67</i>			
22o. SIGNATURE <i>W.P. Stephens</i>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <i>Corinth Hill St. Annapolis, MD.</i>
23o. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>MAY 1, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>GLEN HAVEN CEM.</i>	23d. LOCATION (City or Town) <i>Glen Burnie</i>	(County) <i>A.A. C. #10</i> (State) <i>Md.</i>
24. FUNERAL DIRECTOR <i>John M. Taylor</i>	ADDRESS <i>Sons Funeral Home</i>	25a. REC'D BY REGISTRAR <i>MAY 2 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

04528

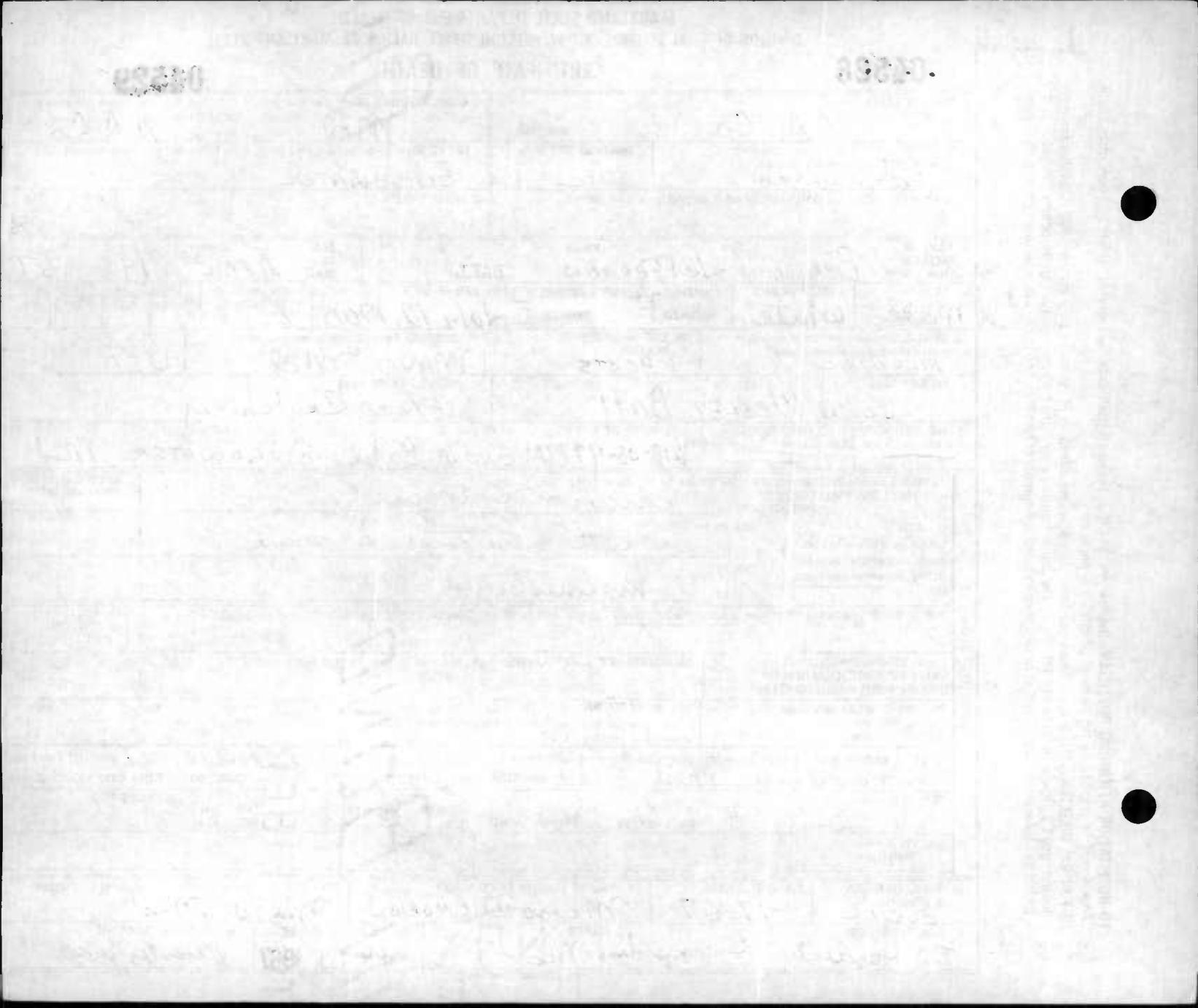
**CERTIFICATE OF DEATH**

04529

1. PLACE OF DEATH a. COUNTY <u>AA Co</u>  b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u>  c. LENGTH OF STAY IN TB <u>Life</u>  d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u>  b. COUNTY <u>AA Co</u>  c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u>		
3. NAME OF DECEASED (Type or print) <u>Benjamin Jefferson</u>			First <u>B</u>	Middle <u>enjamin</u>	Last <u>Jefferson</u>
4. DATE OF DEATH	Month <u>APRIL</u>	Day <u>14</u>	Year <u>1967</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
S. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 12, 1900</u>	9. AGE (In years last birthday) <u>66</u> Yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MECHANIC</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>BOATS</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MAYO, Md</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Wesley Ball</u>	14. MOTHER'S MAIDEN NAME <u>Eliza Cutchley</u>		Address <u>ENO LA Ball, Edgewater, Md</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. <u>318-05-4779A</u>		17. INFORMANT <u>ENO LA Ball, Edgewater, Md</u>	INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>14119</u> DUE TO <u>Carcinoma tongue</u>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO <u>with metastases to neck.</u>					
stating the underlying cause (c) DUE TO <u>malnutrition</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>MAYO</u>	(County) <u>Md</u> (State) <u></u>
21. I certify that (I) (this hospital) attended the deceased from <u>1966</u> , to <u>April 14, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 1967</u> , and that death occurred at <u>11 P.M.</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>Emily H. Wilson, M.D.</u>			22b. DATE SIGNED <u>APR 19 1967</u>		
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>4-17-67</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Mayo Memorial</u>	23d. LOCATION (City or Town) <u>MAYO</u>	(County) <u>Md</u>	(State) <u></u>
24. FUNERAL DIRECTOR <u>T.A. Hardisty Annapolis, Md</u>	ADDRESS	25a. REC'D BY REGISTRAR <u>APR 19 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #12 Film #G388 112567 PC

## CERTIFICATE OF DEATH

04530

04523

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
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**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>13 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		e. STREET ADDRESS <b>Poplar Ridge Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Dr. John</b>	Middle <b>Patrick</b>	4. DATE OF DEATH Month Day Year <b>April 14 1967</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <b>X</b> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 4, 1888</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dentist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dental</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Canada</b>		12. CITIZEN OF WHAT COUNTRY? <b>Canada</b>	
13. FATHER'S NAME <b>John H. Bell</b>		14. MOTHER'S MAIDEN NAME <b>Mary Delight Kiryan</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>		16. SOCIAL SECURITY NO. <b>Address</b>	
17. INFORMANT <b>Mrs. J.P.Bell Bos 53, Glenburnie, Md</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Chronic pyelonephritis &amp; nephro calcinosis</b> DUE TO (c)	
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>(City or town) (County) (State)</b>
21. I certify that (I) <b>Robert Biern</b> attended the deceased from <b>April 1, 1967</b> , to <b>Apr. 14, 1967</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>Apr. 14, 1967</b> , and that death occurred at <b>M</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Robert Biern</b>		M.D. ATTENDING PHYS. <b>5:00 AM</b> <b>X</b> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>4/14/67</b>
22c. PHYSICIAN'S NAME (Type) <b>Robert O. Biern, M.D.</b>		22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/17/67</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>New Cathedral Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>H.W.Mears &amp; Son 805 N. Calvert St.</b>		25a. REC'D BY REGISTRAR <b>DK 17 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04530

## CERTIFICATE OF DEATH

04531

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b <i></i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>A.A. GEN. HOSPT.</i>		d. STREET ADDRESS <i>660 Americana Dr</i>	
3. NAME OF DECEASED (Type or print)		First <i>Saul</i>	Middle <i>B.</i>
4. DATE OF DEATH	Month <i>APRIL</i>	Day <i>20</i>	Year <i>1967</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>SEPT 10, 1898</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RET. INSURANCE EXECUTIVE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>INSURANCE</i>	11. BIRTHPLACE (County & State, or foreign country) <i>ODESSA RUSSIA</i>
13. FATHER'S NAME <i>JOSEPH BENDER</i>		14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, Unknown) <i>YES</i> <i>WWI</i>		16. SOCIAL SECURITY NO. <i>064-01-9178</i>	17. INFORMANT <i>MRS. JEAN BENDER #2</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>1930</i> DUE TO <i>Brain tumor (glioblastoma multiforme)</i> INTERVAL BETWEEN ONSET AND DEATH <i>about 2 years</i>			
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <i>Baltimore</i> (County) <i>Maryland</i> (State) <i>MD.</i>
21. I certify that (I) (this hospital) attended the deceased from <i>Feb. 1966</i> to <i>4/20, 1967</i> , that (I) (we) last saw the deceased alive on <i>4/19 1967</i> , and that death occurred at <i>5:45 AM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Richard L. Hochman</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>4/20/67</i>
22c. PHYSICIAN'S NAME (Type) <i>Richard L. Hochman, MD</i>		22d. ADDRESS <i>59 Franklin St., Annapolis, Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>APR. 21 1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>BALTIMORE NAT. CEM.</i>
24. FUNERAL DIRECTOR <i>John M. Taylor Sons Annapolis MD</i>		ADDRESS <i></i>	25a. REC'D BY REGISTRAR <i>JPR 24 1967</i>
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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ONE BOTTLE GOT BROKEN - ONE MORE TO GO

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours.

Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**04531**

**CERTIFICATE OF DEATH**

**04532**

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millersville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Odenton</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Knellwood Manor Nursing Home</b>		d. STREET ADDRESS <b>527 Bruce Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Jeremiah</b>	Middle <b>(NMN) Blackhead</b>	4. DATE OF DEATH Month <b>April 20,</b> Year <b>1967</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>XX</b>	8. DATE OF BIRTH <b>June 25, 1898</b>
9. AGE (In years last birthday) <b>68 yrs.</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinery maintenance</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Plastics</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Czechoslovakia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	13. FATHER'S NAME <b>unknown</b>		
14. MOTHER'S MAIDEN NAME <b>unknown</b>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>216-10-1327</b>		17. INFORMANT <b>Virginia L. Precter, same address as deceased friend</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b>		Address <b>INTERVAL BETWEEN ONSET AND DEATH 1 hour</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a). { stating the underlying cause lost. (b) DUE TO (c) <b>Myocardial failure</b>		4 hours	
DUE TO (c) <b>Acute myocardial infarction</b>		4 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Pulmonary emphysema, Chronic bronchitis, Bronchiectasis, Heart failure</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>South River Medical Center</b>
20f. (City or town) <b>Odenton</b>		(County) <b>Anne Arundel Md.</b>	
(State) <b>21. I certify that (I) (this hospital) attended the deceased from <b>March 13, 1967</b>, to <b>April 20, 1967</b>, that (I) (we) last saw the deceased alive on <b>April 20, 1967</b>, and that death occurred at <b>7:25 PM</b>, from causes and on the date stated above.</b>		(State)	
22a. SIGNATURE <b>Charles W. Kinzer</b>		22b. DATE SIGNED <b>April 20, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles W. Kinzer, M. D.</b>		22d. ADDRESS <b>South River Medical Center Edgewater, Maryland 21037</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>April 22, 1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Epiphany Episcopal</b>	23d. LOCATION (City or Town) <b>Odenton</b>
24. FUNERAL DIRECTOR <b>Beverley E. Hopping</b>	ADDRESS <b>Beverley E. Hopping</b>	HOPPING FUNERAL HOME - Annapolis, Maryland	25a. REC'D BY REGISTRAR <b>Charles Judge</b>
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	DATE APR 24 1967		

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canter south of R.

Rock to 600 ft. to N. base L. 10

US Date

concretion

shallow

Soil 600 ft. to base

L. 10

alluvium

soluble

non-soluble fraction

soluble

soluble

selected as sample core 600 ft. to N. base L. 10

core I

core J

gravel lenses

core K

no fossiliferous zone

selected surface, 600 ft. to N. base L. 10, 25 ft.

100 ft. thick to 100 ft. above

100 ft. thick to 100 ft.  
selected surface, 600 ft. to N. base L. 10



RECEIVED

38620

(total letters written) 0-9

2  
1 M

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

04533

**CERTIFICATE OF DEATH**

04534

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~have~~ have carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Anne Arundel</i>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>MILLERSVILLE</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>EDGEMEATER</i>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Knowlwood Nursing Home</i>				d. STREET ADDRESS <i>Box 28 Rt #4</i>									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) <i>ELLEN</i>		First <i>G.</i>	Middle <i>BOWEN</i>	Last <i></i>	4. DATE OF DEATH <i>APRIL 4 1967</i>	Month <i>APRIL</i>	Day <i>4</i>	Year <i>1967</i>					
S. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JULY 10, 1880</i>	9. AGE (In years last birthday) <i>86</i>	IF UNDER 1 YEAR Months <i></i>	IF UNDER 24 HRS. Days <i></i>	Hours <i></i>	Min. <i></i>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Supervisor</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>RETAIL CLOTHING</i>				11. BIRTHPLACE (County & State, or foreign country) <i>YPSLANTI MICHIGAN U.S.A.</i>					
13. FATHER'S NAME <i>JOHN R GUNN</i>				14. MOTHER'S MAIDEN NAME <i>ANN PURTEL</i>				12. CITIZEN OF WHAT COUNTRY <i></i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>377104359A</i>		17. INFORMANT <i>CHANCY F. WHITNEY #2</i>		Address <i></i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN DEATH AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic cancer of breast</i>										<i>YESTERDAY</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) _____ stating the underlying cause last. (c) _____													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>None</i>										19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>30 June 1967</i>		20f. (City or town) <i>4 April</i>		(County) <i>67</i>		(State)	
21. I certify that (I) (this hospital) attended the deceased from <i>19</i> to <i>19</i> , that (I) (we) last saw the deceased alive on <i>2 April 1967</i> , and that death occurred at <i>2:40 P.M.</i> from causes and on the date stated above.													
22a. SIGNATURE <i>Charles W. Kinzer</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <i>4 April 1967</i>					
22c. PHYSICIAN'S NAME (Type) <i>Charles W. Kinzer, M. D.</i>				22d. ADDRESS <i>South River Medical Center Edgewater, Maryland 21037</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>4-13-67</i>		23c. NAME OF CEMETERY OR CREMATORIES <i>ST. JOHNS CATHOLIC CEM.</i>				23d. LOCATION (City or Town) <i>YPSLANTI</i>					
24. FUNERAL DIRECTOR <i>John M. Taylor &amp; Sons Annapolis, Md.</i>				ADDRESS <i></i>				25a. REC'D BY REGISTRAR <i>APR 6 1967</i>					
								25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

8820

8820

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**04534**

**CERTIFICATE OF DEATH**

**04535**

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis q</b>		c. LENGTH OF STAY IN lb <b>life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis 22-1</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>813 Chesapeake Ave.,</b>			d. STREET ADDRESS <b>813 Chesapeake Ave.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First <b>Thomas</b>	Middle <b>Joseph</b>	Last <b>Branzell</b>	4. DATE OF DEATH <b>April 10 1967</b>	Month Day Year	
5. SEX <b>male</b>	6. COLOR DR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 25, 1886</b>	9. AGE (In years last birthday) <b>80 yrs.</b>	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US Gov't</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Annapolis, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>William T. Branzell</b>						
14. MOTHER'S MAIDEN NAME <b>Harriett Ann Denver</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>214-05-0751</b>		17. INFIRMITY Address <b>Thomas M. Branzell - Riva Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malina</b> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the cause (a), stating the underlying cause last. (b) <b>Ch. nephritis</b> DUE TO (c)						
INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Bm in hypertension Prost</b>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Ange 2, 1967, to April 10, 1967</b>		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Ange 2, 1967, to April 10, 1967</b> , that (I) (we) last saw the deceased alive on <b>Apr 10, 1967</b> , and that death occurred at <b>3157</b> M, from the causes and on the date stated above.						
22a. SIGNATURE <b>Maurice F. Shawans,</b>		22b. DATE SIGNED <b>3157</b>				
22c. PHYSICIAN'S NAME (Type) <b>Maurice F. Shawans</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>3157</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 12, 1967</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>St. Mary's Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Annapolis, A.A. Md.</b>
23e. FUNERAL DIRECTOR <b>Hopping</b>		23f. ADDRESS <b>Bonney E. Hopping</b>		23g. REC'D BY REGISTRAR <b>APR 13 1967</b>		23h. REGISTRAR'S SIGNATURE <b>Charles Judge</b>
VR A15 (4) 15M 4-64						

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04535

CERTIFICATE OF DEATH

04536

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL ANNAPOLIS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL ANNAPOLIS</b>		
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <b>RIVA ROAD</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>GREEN GABLES</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>PAUL</b> First <b>H.</b> Middle <b>BRATTAIN</b> Lost		4. DATE OF DEATH Month <b>APRIL</b> Day <b>21</b> Year <b>1967</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>FEB. 4, 1894</b> 73 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>AIRLINES EXECUTIVE</b>		11. BIRTHPLACE (County & State, or foreign country) <b>INDIANAPOLIS IND.</b>		
10b. KIND OF BUSINESS OR INDUSTRY <b>TRANSPORT</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13. FATHER'S NAME <b>HENRY EDGAR BRATTAIN</b>		14. MOTHER'S MAIDEN NAME <b>MARTHA V. RANSDALE</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>NELLIE M. BRATTAIN #2</b> Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RENAL CARCINOMA</b> DUE TO 180X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>1 YEAR</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>CEREBRAL METASTASES</b>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>ANNAPOLIS</b> (County) <b>ANNE ARUNDEL</b> (State)
21. I certify that (I) (this hospital) attended the deceased from <b>MAY</b> , 1967, to <b>21 APR</b> , 1967, that (I) (we) last saw the deceased alive on <b>20 APR</b> , 1967, and that death occurred at <b>1152 AM</b> , from causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
22a. SIGNATURE <b>Edward S Beck</b>		22b. DATE SIGNED <b>4/22/67</b>		
22c. PHYSICIAN'S NAME (Type) <b>EDWARD S BECK</b>		22d. ADDRESS <b>71 FRANKLIN ST ANNAPOLIS MD</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>APR 24 1967</b>		
23c. NAME OF CEMETERY OR CREMATORIAL <b>HILLCREST CEM.</b>		23d. LOCATION (City or Town) <b>ANNAPOLIS AAC MD.</b> (County) <b>ANNE ARUNDEL</b> (State)		
24. FUNERAL DIRECTOR <b>JOHN M. TAYLOR &amp; SONS ANNAPOLIS MD</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b> DATE <b>APR 25 1967</b>		
ADDRESS		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04536

CERTIFICATE OF DEATH

04537

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN lb 7 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		d. STREET ADDRESS 2906 Dungate Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Laura Middle Catherine Last Brooks		4. DATE OF DEATH Month April Day 22 Year 1967	
S. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 2, 1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Samuel T. Dunlap		14. MOTHER'S MAIDEN NAME Laura M. Ellison	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO. None	
17. INFORMANT (Husband)		Address William A. Brooks same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Thrombosis</i> DUE TO <i>48 hrs</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Cardio Vascular Disease</i> DUE TO <i>6 yrs</i> last. (c) <i>Hypertension</i> DUE TO <i>Year</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Atrial Myocardial Infarction</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>4-15</i> , 1967, to <i>4-22</i> , 1967, that (I) (we) last saw the deceased alive on <i>4-22</i> , 1967, and that death occurred at <i>12:00 PM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Hilary O'Herlihy</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>4-22-67</i>
22c. PHYSICIAN'S NAME (Type) Hilary O'Herlihy M.D.		22d. ADDRESS #5 Central Ave. Glen Burnie, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 25, 1967	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mt. Carmel Church Cem.		23d. LOCATION (City or Town) (County) (State) Anne Arundel, Pasadena, Md.	
24. FUNERAL DIRECTOR Richard V. Singleton		25a. REC'D BY REGISTRAR APR 24 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
		DATE	

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04537

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04538

1. PLACE OF DEATH  
e. COUNTY

Anne Arundel

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Annapolis

c. LENGTH OF STAY IN lb

Dot

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

D.O.A Anne Arundel General

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

ALICE

MARIE

BROWN

5. SEX

6. COLOR OR RACE

female

white

7. MARRIED  NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

Jan. 20, 1905

9. AGE (In years  
last birthday)

62

yrs.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

housewife

10b. KIND OF BUSINESS OR INDUSTRY

own home

13. FATHER'S NAME

John E. Eades

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give war or dates of service)

no

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

hone

17. INFORMANT

Cora Higgins

Address

Carl C. Brown-husband

same as #2 above

INTERVAL BETWEEN  
ONSET AND DEATH

Obituary

IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which  
gave rise to immediate cause

(e), stating the underlying

cause last.

(b)

DUE TO

(c)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES

NO

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS  
PRIMARY  or CONTRIBUTING   
CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m. 19  
p.m.

20d. INJURY OCCURRED While Not While  
at work  at work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion  
death resulted from Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

Address (Street, city, town, or county)

4/18/67

22a. BURIAL, CREMATION, DATE THEREOF  
REMOVAL (Specify)

Burial

May 1, 1967

22b. NAME OF CEMETERY OR CREMATORIUM

Hillcrest Cemetery

22d. LOCATION (City, town, or country)

Annapolis Anne Arundel Md.

(State)

23. FUNERAL DIRECTOR

Beverley E. Hopping

Hopping Funeral Home

ADDRESS

Beverley E. Hopping  
Annapolis, Maryland

24a. REC'D BY REGISTRAR

MAY 2 1967 Charles Judge

24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any part is necessary, please execute it in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

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5M 1/62

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FOR STATE  
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in the space. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04538

04539

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			c. LENGTH OF STAY IN 1b MARYLAND		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			d. STREET ADDRESS <b>19 Morris Street</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Clay Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <b>ERNEST</b>	Middle <b>A.</b>	Lost	4. DATE OF DEATH Month <b>4</b> Doy <b>3</b> Year <b>19 67</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>1-6-1941</b>	9. AGE (In years lost birthday) <b>26 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Scalp</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>a-a Corp fail</b>	11. BIRTHPLACE (State or foreign country) <b>Md</b>		IF UNDER 24 HRS. Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
13. FATHER'S NAME <b>Theodore Brown</b>		14. MOTHER'S MAIDEN NAME <b>Hattie T. Way</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>70</b>	17. INFORMANT <b>Hattie T. Way, Anna</b>	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>976X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot self in head</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>3:00 p.m. 4 3 1967</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>House</b>	20f. (City or town) <b>Annapolis</b>	(County) (State) <b>A.A. Md</b>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Werner U. Spitz</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.			
EXAMINER'S NAME (Type) <b>WERNER U. SPITZ, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <b>Annapolis, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-6-67</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Brewer Hill</b>	23d. LOCATION (City or Town) <b>Annapolis</b>	(County) (State) <b>Md</b>
24. FUNERAL DIRECTOR <b>William Reese # Annapolis</b>		ADDRESS	25a. RECD BY REGISTRAR <b>APR 5 1967</b>	25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	

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2000-2001:  $\text{C} = \text{C}_1 + \text{C}_2$

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04533

Item #8 Film #G388 1/25/67 pc

## CERTIFICATE OF DEATH

Reg. Dist. No.

04540

1. PLACE OF DEATH o. COUNTY A.A.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md.		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto.		d. STREET ADDRESS 3708 Elm Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1624 Tieman Dr.				d. STREET ADDRESS 3708 Elm Ave.				
3. NAME OF DECEASED (Type or print) Gladys M. Buell		First	Middle	Last	4. DATE OF DEATH 4/15/67	Month	Day	Year 19
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 11/24/05 24/12/05/	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sewing Machine Opp.		10b. KIND OF BUSINESS OR INDUSTRY Textile		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-22-3624		17. INFORMANT Vanessa Smith 1624 Tieman Dr.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1750		Intestinal obstruction				INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		carcinoma, ovarian, with metastasis				48 hrs.		
DUE TO (c)						14 mo.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 901 Cathedral Street	(County)	(State)
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 4-19-67								
ACTUAL SIGNATURE <i>Arnold L. Field</i>		Baltimore, Maryland						
PHYSICIAN'S NAME (Type) Arnold L. Field								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/19/67		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill		22d. LOCATION (City, town, or county) (State) Glen Burnie, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Paul E. Hanowell</i>		ADDRESS 3617 Beaufort Ave.		24a. REC'D BY REGISTRAR APR 20 1967		24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

5393

CERTIFICATE OF DEATH



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STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
ALBANY, N.Y.  
CERTIFICATE OF DEATH

For the following deceased person, whose death occurred on the \_\_\_\_\_ day of \_\_\_\_\_, A.D. \_\_\_\_\_, at \_\_\_\_\_, in the County of \_\_\_\_\_, State of New York, I do hereby certify that he died of \_\_\_\_\_.

I further certify that the deceased was \_\_\_\_\_ years of age, and in the \_\_\_\_\_ month of \_\_\_\_\_, A.D. \_\_\_\_\_, he was born in \_\_\_\_\_, State of \_\_\_\_\_.

The deceased was \_\_\_\_\_ years of age, and in the \_\_\_\_\_ month of \_\_\_\_\_, A.D. \_\_\_\_\_, he was born in \_\_\_\_\_, State of \_\_\_\_\_.

The deceased was \_\_\_\_\_ years of age, and in the \_\_\_\_\_ month of \_\_\_\_\_, A.D. \_\_\_\_\_, he was born in \_\_\_\_\_, State of \_\_\_\_\_.

The deceased was \_\_\_\_\_ years of age, and in the \_\_\_\_\_ month of \_\_\_\_\_, A.D. \_\_\_\_\_, he was born in \_\_\_\_\_, State of \_\_\_\_\_.

The deceased was \_\_\_\_\_ years of age, and in the \_\_\_\_\_ month of \_\_\_\_\_, A.D. \_\_\_\_\_, he was born in \_\_\_\_\_, State of \_\_\_\_\_.

The deceased was \_\_\_\_\_ years of age, and in the \_\_\_\_\_ month of \_\_\_\_\_, A.D. \_\_\_\_\_, he was born in \_\_\_\_\_, State of \_\_\_\_\_.

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FOR STATE  
HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04540

04541

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>ANNAPOLIS ST. MARY'S</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		d. STREET ADDRESS <b>Crownsville Chaptico</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Crownsville State Hospital</b>				d. STREET ADDRESS		<b>Crownsville State Hospital</b>			
3. NAME OF DECEASED (Type or print)		First <b>MARY</b>	Middle <b>C.</b>	Lost	4. DATE OF DEATH	Month <b>4</b>	Doy <b>23</b>	Year <b>1967</b>	
S. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	B. DATE OF BIRTH <b>6-11-25</b>	9. AGE (In years last birthday) <b>14241 yrs.</b>	IF UNDER 1 YEAR Months <b>14241</b>	IF UNDER 24 HRS. Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b>	IF UNDER 24 HRS. Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>WILLIAM SHADE</b>				14. MOTHER'S MAIDEN NAME <b>LILLIAN THOMAS</b>		Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>RICHARD BUTLER</b>		18. COUNTRY <b>CHAPTICO, MARYLAND</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar pneumonia</b>						INTERVAL BETWEEN ONSET AND DEATH			
490X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO									
{ stating the underlying cause last. (c) DUE TO									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
Fatty liver									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <b>While at work</b>		20c. TIME OF INJURY Month, Doy, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>R.S. Fisher</i>		M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <b>4-24-67</b>			
EXAMINER'S NAME (Type) <b>RUSSELL S. FISHER, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>APRIL 28, 1967</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>SACRED HEART CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>BUSHWOOD, ST. MARY'S, MARYLAND</b>			
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>MR. IVAN J. COOPER</b>		25b. REGISTRAR'S SIGNATURE <i>Ivan J. Cooper</i>			

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PN3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04541

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04542

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>2 yrs. 4 mos.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Crownsville State Hospital</b>		d. STREET ADDRESS <b>Unknown</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>3-#27957</b>	Middle <b>Walter</b>	Last <b>Chandoha</b>	4. DATE OF DEATH Month <b>4</b>	Month <b>4</b>	Day <b>10</b>	Year <b>1967</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>8/8/24</b>	9. AGE (In years last birthday) <b>42</b> yrs.	IF UNDER 1 YEAR Months <b>42</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Pittsburgh, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Matthew Chandoha</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>200-14-8672</b>		17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Intra-peritoneal Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) stating the underlying cause (c) <b>Ruptured Spleen</b>							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Fracture of left orbital plate, Superior</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> 3 at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Elmer G. Linhardt</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>April 1967</b>	
EXAMINER'S NAME (Type) <b>Elmer G. Linhardt, M. D.</b>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-21-67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Balto. National Cem</b>		23d. LOCATION (City or Town) (County) (State) <b>Balto. Md.</b>	
24. FUNERAL DIRECTOR <b>Morton &amp; Dyett F.H.</b>		ADDRESS <b>1701 Laurens St.</b>		25a. REC'D. BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

3470

1970

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04542

04543

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundal MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundal				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundal Hospital			d. STREET ADDRESS 18 Wallace Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) R. Frank		First J.	Middle	Last Chesebrough	4. DATE OF DEATH April 27 1967	Month Doy Year	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-26-03	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Manager		10b. KIND OF BUSINESS OR INDUSTRY Trucking co.		11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Claude Chesebrough			14. MOTHER'S MAIDEN NAME Zonia Hombeck			Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 093-18-2526		17. INFORMANT Mrs. Pattie Chesebrough		18. Cause of Death (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Due To <i>Claude Myocardial infarction</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Due To <i>Diffuse Myocardial disease</i> (c)	INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/27, 1967 to 4/21, 1967, that (I) (we) last saw the deceased alive on 4/27 1967, and that death occurred at 116 P.M. from causes and on the date stated above.							22b. DATE SIGNED 4/29/67
22a. SIGNATURE <i>William S. Linsao</i>		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) G. S. Linsao M.D.		22d. ADDRESS 7308 Furnace Branch Road					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-1-67		23c. NAME OF CEMETERY OR CREMATORIUM Ayden Cemetery		23d. LOCATION (City or Town) (County) (State) Pitt County North Carolina	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Inc.		ADDRESS 1217 St. Paul Street		25a. REC'D BY REGISTRAR MAY 2 1967		25b. REC'D REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
VR A15 (4) 20 M 1/66				DATE			

100

3 1 AM

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04544

04543

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
o. COUNTY <b>Anne Arundel</b>		o. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN lb <b>8 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis - RURAL</b>		d. STREET ADDRESS <b>Rt. 4, Box 379B</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lavern</b>		First <b>E</b>	Middle <b>CLAPP</b>
4. DATE OF DEATH <b>April 5, 1967</b>	Month <b>April</b>	Doy <b>5</b>	Year <b>1967</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>December 14, 1885</b>
9. AGE (In years lost birthday) <b>81 yrs.</b>		10. KIND OF BUSINESS OR INDUSTRY <b>TIRE CO</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Michigan</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		13. FATHER'S NAME <b>Retired Eng.</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>Edward J. Clepp - Gloue</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>527.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		<b>Congestive heart failure</b> <b>Ed pulmonale</b> <b>Pulmonary embolism</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Hypertension, RT. medullar cerebri</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>121 Cathedral St., Annapolis, Md.</b>
20f. (City or town) <b>121 Cathedral St., Annapolis, Md.</b>		(County) <b>Anne Arundel Co., Maryland</b>	
(State) <b>Ohio</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>3/28</b> , 19 <b>62</b> , to <b>4/5</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>4/5</b> , 19 <b>67</b> , and that death occurred at <b>7:30 P.M.</b> from causes and on the date stated above.		22b. DATE SIGNED <b>4/6/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Richard N. Peeler, M.D.</b>		22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>	
23a. BURIAL/CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-8-67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Rose Hill Cem. Summit Co., Ohio</b>
23d. LOCATION (City or Town) <b>Summit Co., Ohio</b>		(County) <b>Ohio</b>	
24. FUNERAL DIRECTOR <b>Robert J. Baranay, Funeral Dir.</b>		25a. ADDRESS <b>ROBERT J. BARANAY, Funeral Dir.</b>	25b. REC'D BY REGISTRAR <b>APR 10 1967</b>
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

BACAO

NAME OF GROWER

66250

Concord

bush

long

1000 - 1100

avg 6

all green

very few red

red color intense yellow tan

large size

large size

10 100% ripe

medium

1000

yellow & brownish

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1

04544

## CERTIFICATE OF DEATH

04546

20  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and 2 pages and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1. PLACE OF DEATH o. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <i>MD.</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>MD.</i>		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>N. Arundel Hospital</i>		d. STREET ADDRESS <i>308 Balsom Dr.</i>	
3. NAME OF DECEASED (Type or print) <i>Roger J. Cummings</i>		First <i>Roger</i>	Middle <i>J.</i>
3. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>10-8-1910</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CIVIL SERVICE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>V. Adm.</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>LETHBRIDGE CANADA</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Ford J. Cummings</i>		14. MOTHER'S MAIDEN NAME <i>Edith J. Owen</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>YES</i>		16. SOCIAL SECURITY NO. <i>224 60 5412</i>	17. INFORMANT <i>CATHERINE R. Cummings #2</i>
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Myocardial infarction</i>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) <i>E.C.V.D.</i> (c) <i>Gernard</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>
21. I certify that (I) (this hospital) attended the deceased from <i>1965</i> , 19, to <i>1967</i> , 19, that (I) (we) last saw the deceased alive on <i>4-28-67</i> , 19, and that death occurred at <i>10A.M.</i> from causes and on the date stated above.		20f. (City or town) <i></i> (County) <i></i> (State) <i></i>	
22a. SIGNATURE <i>Robert R. Hahn</i>		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <i>Robert R. HAHN.</i>		22d. ADDRESS <i>Po. Box 73 Severna Park</i>	22b. DATE SIGNED <i>4-29-67</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>CREMATION</i>		23b. DATE THEREOF <i>5-1-67</i>	23c. NAME OF CEMETERY OR, CREMATORIUM <i>Ft. Lincoln</i>
24. FUNERAL DIRECTOR <i>John M. Taylor &amp; Sons Annapolis, Md.</i>		ADDRESS <i></i>	23d. LOCATION (City or Town) <i>BADENSBURG</i> (County) <i>M.D.</i>
			25a. REC'D. BY REGISTRAR DATE <i>MAY 2 1967</i>
			25b. DIRECTOR'S SIGNATURE <i>James Judge</i>

04240

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U.S. MUNICIPAL BOND

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M

210 CIVIL SERVICE UNION. FEDERAL TRADE COMMISSION  
# 1050 4. COMM. & LABOR  
# 34402418 CIVIL SERVICE B.C. COMM.

Q.S. S.  
Prescott

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04545

## CERTIFICATE OF DEATH

04547

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Crownsville</i>		c. LENGTH OF STAY IN lb <i>2 years</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		d. LENGTH OF STAY IN lb <i>30·4</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>CROWNSVILLE STATE HOSP</i>		e. STREET ADDRESS <i>939 N. Broadway</i>	
3. NAME OF DECEASED (Type or print) <i>GEORGE P. DAVIS</i>		First <i>GEO</i>	Middle <i>P.</i>
4. DATE OF DEATH <i>4/13/67</i>	Month <i>4</i>	Doy <i>1</i>	Year <i>1967</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>N</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>12/23/06</i>
9. AGE (In years lost birthday) <i>60 yrs.</i>	10. IF UNDER 1 YEAR <i>12 mos</i>	11. IF UNDER 24 HRS. <i>23 days</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mail Clerk</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Post Office</i>	11. BIRTHPLACE (County & State, or foreign country) <i>S.C.</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Henry Davis</i>	14. MOTHER'S MAIDEN NAME <i>Harriet Davis</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>213-07-4686</i>	17. INFORMANT <i>Hospital Records</i>	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4500</i> DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) DUE TO (c)			
Causes pulmonary Failure Pulmonary arterial sclerosis			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
Inanition			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <i>ME</i> (this hospital) attended the deceased from <i>5/13/65</i> , 19 to <i>4/16/67</i> , 19, that <i>ME</i> (we) last saw the deceased alive on <i>4/16/67</i> , 19, and that death occurred at <i>2709</i> M., fram causes and on the date stated above.			
22a. SIGNATURE <i>Benjamin M.D.</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>4/16/67</i>
22c. PHYSICIAN'S NAME (Type) <i>Benjamin M.D.</i>		22d. ADDRESS <i>Crownsville State Hospital</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>4-5-67</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Calvary Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Anne Arundel Co., Md.</i>
24. FUNERAL DIRECTOR <i>Randolph J. Collick 2431 E. Oliver St.</i>	ADDRESS <i>Randolph J. Collick 2431 E. Oliver St.</i>	25a. REC'D BY REGISTRAR <i>APR 5 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

SECRET

NAME TO REPORTER

20240

1  
FOR STATE  
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04546

Item #9 Form #C388 4/25/67 pg

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04548

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Annapolis		Annapolis		Reva Land - Route 5	
3. NAME OF DECEASED (Type or print)		First	Middle	Last (Diggs)	DATE OF DEATH	Month	Day Year
4. SEX		6. COLOR OR RACE	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		Unknown		Unknown		U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		4500 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
MEDICAL CERTIFICATION							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE 							
EXAMINER'S NAME (Type) E. L. Whitbeck							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town or county) (State)	
Burial 4-19-67				Brewer Hill Cemetery		Annapolis Md.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
William Beesett Annapolis				APR 19 1967		Charles J. Moore	
DATE							

26200

262

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5, may be retained for your files.

10 FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

04547

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04549

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Anne Arundel</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b <i>DOA</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Edgewater</i>		d. STREET ADDRESS <i>Pine Wharf Beach</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in Hospital, give street address) <i>Anne Arundel General</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <i>Elmer</i>	Middle <i>E.</i>	Last <i>Doolan</i>	4. DATE OF DEATH <i>April 29 1967</i>	Month <i>April</i>	Day <i>29</i>	Year <i>1967</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>Dec. 11, 1892</i>	9. AGE (In years last birthday) <i>75 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Hours <i>0</i>	12. IF UNDER 24 HRS. Minutes <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Supervisor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Dept. Horticulture</i>		11. BIRTHPLACE (State or foreign country) <i>Cincinnati, Ohio</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>John Doolan</i>		14. MOTHER'S MAIDEN NAME <i>Emma Veth</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>220-44-1805</i>		17. INFORMANT <i>Elsie Doolan</i>		Address <i>#2</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>4344</i> DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last: (b) DUE TO (c)		Cardiac Disease		INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Elmer G. Linhardt</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <i>May 1, 1967</i>				
EXAMINER'S NAME (Type) <i>ELMER G. LINHARDT</i>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
Address (Street, city, town, or county) <i>Bladensburg Md.</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>5-2-67</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Ft. Lincoln Cemetery</i>		23d. LOCATION (City or Town) <i>Bladensburg</i>		
24. FUNERAL DIRECTOR <i>John M. Layton Sons Annapolis, Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
VR A15ME (5) 6M 1/66		DA MAY 2 1967						

64 probably *petersoni* A. (d-s-e pattern)  
bill, wings and whitish tail

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)										
AA. Co MARYLAND				a. STATE b. COUNTY										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arnold				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arnold										
c. LENGTH OF STAY IN 1b 12 years														
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Broadwater - Rt 1 Box 353				d. STREET ADDRESS Broadwater Rt 1 Box 353										
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year						
ETHEL		AIKEN		DOYLE	4	8	1967							
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-21-58	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (County & State, or foreign country) Md	12. CITIZEN OF WHAT COUNTRY USA									
13. FATHER'S NAME Matthew Aiken			14. MOTHER'S MAIDEN NAME Virginia Jerome	Address Mr. Arthur Doyle - above										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 443X	17. INFORMANT	INTERVAL BETWEEN ONSET AND DEATH 10 minute									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema											
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. 443X			DUE TO (b) Hypertensive Cardio-vascular Heart Disease 10yrs											
DUE TO (c)														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. While at work <input type="checkbox"/> Not White at work <input type="checkbox"/> p.m. 19			20d. INJURY OCCURRED			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from , 1967, to Apr , 1967, that (I) (we) last saw the deceased alive on April 5 1967 and that death occurred at 7:30 PM the causes and on the date stated above.														
22a. SIGNATURE Francis I. Codd M.D.			22b. DATE SIGNED 4-11-67											
22c. PHYSICIAN'S NAME (Type) Francis I. Codd M.D.			22d. ADDRESS Severna Park, Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 4-11-67			23c. NAME OF CEMETERY OR CREMATORIAL Greenmount Cemetery			23d. LOCATION (City, town, or county) Baltimore					
24. FUNERAL DIRECTOR Charles J. Banane, Severna Park, Md			25a. REC'D BY REGISTRAR APR 12 1967 25b. REGISTRAR'S SIGNATURE Charles J. Banane											

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04543

CERTIFICATE OF DEATH

04551

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

I. PLACE OF DEATH o. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	c. LENGTH OF STAY IN lb <i>50 years.</i>	b. COUNTY <i>AA</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>111 Smith Avenue</i>		d. STREET ADDRESS <i>111 Smith Avenue</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>PAUL</i>	Middle <i>CHARLES</i>	Last <i>DUNLEAVY</i>
4. DATE OF DEATH Month <i>4</i>	Year <i>6</i>	Day <i>19</i>	Year <i>1967</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-22-1913</i>
9. AGE (In years lost birthday) <i>53 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>PROFESSOR NAVAL AC. NAVAL ACADEMY</i>	11. BIRTHPLACE (County & State, or foreign country) <i>PHILADELPHIA, PENN</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>PAUL DUNLEAVY</i>	14. MOTHER'S MAIDEN NAME <i>JENNIE TLOSE</i>	15. ADDRESS <i>(SAME)</i>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>	17. SOCIAL SECURITY NO. <i>218-03-6799</i>	18. INFORMANT <i>AMES DUNLEAVY</i>	19. INTERVAL BETWEEN ONSET AND DEATH <i>9 weeks</i>
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>STARVATION, DEHYDRATION, CACHEXIA</i> <i>157X</i>		DUE TO (b) <i>METASTATIC (TO LIVER (and brain?))</i> Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. DUE TO (c) <i>ADENO-CARCINOMA OF PANCREAS</i>	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Dee.</i>	20f. (City or town) <i>Dee.</i> (County) <i>Dee.</i> (State) <i>Dee.</i>
21. I certify that (I) (this hospital) attended the deceased from <i>Dee. 1965</i> to <i>4/16 1967</i> that (I) (we) last saw the deceased alive on <i>4-6 1967</i> , and that death occurred at <i>10:40P</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Peter F. Verkouw</i>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <i>PETER F. VERKOUW</i>	22b. DATE SIGNED <i>4-6-1967</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>4-10-67</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>CEDAR Bluff</i>	23d. LOCATION (City or Town) (County) (State) <i>Annapolis</i> <i>Md.</i>
24. FUNERAL DIRECTOR <i>John M. Taylor et al Annapolis, Md.</i>	25a. REC'D BY REGISTRAR <i>APR 10 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

13520

81520

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04550

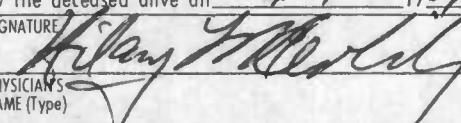
## CERTIFICATE OF DEATH

04552

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel County</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Glen Burnie</b>	c. LENGTH OF STAY IN lb <b>Five hours</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, rural</b>	d. STREET ADDRESS <b>504 Taney Ave.</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>North Arundel Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Louis</b>	Middle <b>J.</b>	Last <b>Eckert</b>
4. DATE OF DEATH	Month <b>April 1</b>		Day Year <b>19 67</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>8-14-17</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>American Oil Co.</b>	9. AGE (In years last birthday) <b>49 yrs.</b>
10c. CITIZEN OF WHAT COUNTRY? <b>United States</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>	12. IF UNDER 1 YEAR Months Days Hours Min.
13. FATHER'S NAME <b>Samuel B. Eckert</b>		14. MOTHER'S MAIDEN NAME <b>Helene Hahn</b>	Address
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>207-03-8726</b>	17. INFORMANT <b>Mrs. Alice Eckert - same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>057.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) DUE TO (c)			REPTILICMIC SHOCK INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <b>Metastatic carcinoma</b>			24 hours
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>4-1 - 1967</b> , to <b>4-1 - 1967</b> , that (I) (we) last saw the deceased alive on <b>4-1 - 1967</b> , and that death occurred <b>4-1 - 1967</b> M, from causes and on the date stated above.			
22a. SIGNATURE 	M.D. <input type="checkbox"/> ATTENDING PHYS. <b>MD</b> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>4-1-67</b>	
22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4-5-1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Cedar Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Ritchie Hwy., A.A.C.O., Md.</b>
24. FUNERAL DIRECTOR <b>George J. Gonce-4001 Ritchie Hwy., Baltimore</b>	25a. REC'D BY REGISTRAR DATE <b>APR 6 1967</b>	25b. REGISTRAR'S SIGNATURE 	

09225

09226

Rock wall

Rock wall

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04551

## CERTIFICATE OF DEATH

04553

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH o. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>1 year</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Convalescent Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <u>MARY</u>	Middle <u>MARGARET</u>	Last <u>EHART</u>
4. DATE OF DEATH Month <u>APRIL</u> Day <u>2</u> Year <u>1967</u>	5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>JULY 9-1882</u>	9. AGE (In years lost birthday) <u>84 yrs.</u>	10. IF UNDER 1 YEAR <input type="checkbox"/> Months <u>-</u> Dows <u>-</u> Hours <u>-</u> Min. <u>-</u>	11. IF UNDER 24 HRS. Months <u>-</u> Dows <u>-</u> Hours <u>-</u> Min. <u>-</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>not</u> <u>House</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore - Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>JOSEPH WEIGAND</u>	14. MOTHER'S MAIDEN NAME <u>CATHERINE BANKS</u>	Address <u>308 E Maple St</u> <u>Washburn 1263.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	16. SOCIAL SECURITY NO. <u>216-03-09620</u>	17. INFORMANT <u>Mr Francis Chart</u>	18. INTERVAL BETWEEN ONSET AND DEATH <u>hours</u>
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <u>left ventricular failure</u> 4500 DUE TO Conditions, if any, which gave rise to immediate cause (o). stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Chronic congestive heart failure</u> year.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <u>Hypertension, right; chronic brain syndrome.</u>			
20. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>/</u>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <u>/</u>		
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>p.m.</u> <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> off work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>/</u>	20f. (City or town) <u>/</u> (County) <u>/</u> (State) <u>/</u>
21. I certify that (I) (this hospital) attended the deceased from <u>3/30</u> , 19 <u>67</u> to <u>4/2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/2</u> 19 <u>67</u> , and that death occurred at <u>9 A.M.</u> from causes and on the date stated above.	22b. DATE SIGNED <u>4/2/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>MAX C FRANK</u>	22d. ADDRESS <u>425 SE Ritchie Hwy - Key Service</u> <u>1202-1061</u>	M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	23d. LOCATION (City or Town) <u>Ritchie Hwy., A.A. Co., Md.</u> (County) <u>/</u> (State) <u>/</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4-5-1967</u>	23c. NAME OF CEMETERY OR CREMATORIALY <u>Holy Cross Cemetery</u>	23d. LOCATION (City or Town) <u>Ritchie Hwy., A.A. Co., Md.</u> (County) <u>/</u> (State) <u>/</u>
24. FUNERAL DIRECTOR <u>George J. Gonce-4001 Ritchie Hwy., Baltimore</u>	ADDRESS	25a. REC'D BY REGISTRAR <u>APR 6 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles George</u>

ERANO

REGG

ERANO REGG

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

04552

04554

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KEELSMIRE SHORES</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>129 Lee Drive</b>		d. STREET ADDRESS <b>129 LEE DRIVE</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>WILLIAM</b>	Middle <b>BEALL</b>	Last <b>ELLINGTON</b>
4. DATE OF DEATH <b>9 28 1967</b>	Month	Day	Year
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-5-66</b>
9. AGE (In years last birthday) yrs. <b>6</b>	IF UNDER 1 YEAR Months <b>6</b>	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>	
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>W<sup>m</sup> Paul Ellington</b>		14. MOTHER'S MAIDEN NAME <b>Susan Lee Fisher</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>W<sup>m</sup> Paul Ellington</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>INTERSTITIAL PNEUMONITIS (SOII)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } (b) lost. } DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>Chestertown</b> (County) <b>Talbot</b> (State) <b>Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Russell S. Fisher</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D.	
EXAMINER'S NAME (Type) <b>RUSSELL S. FISHER, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 1 1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Chesapeake</b>
23d. LOCATION (City or Town) <b>Chesapeake</b> (County) <b>Talbot</b> (State) <b>Md.</b>		23e. LOCATION (City or Town) <b>Chesapeake</b> (County) <b>Talbot</b> (State) <b>Md.</b>	
24. FUNERAL DIRECTOR <b>Marvin V. William Chesapeake Md</b>		ADDRESS	25a. REC'D BY REGISTRAR <b>MAY 2 1967</b>
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

2220

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reprove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04553

Item #8 Film#G387 4/12/67 pg

## CERTIFICATE OF DEATH

04555

1. PLACE OF DEATH a. COUNTY <i>H. A.</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>H. A.</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ken Burne</i>	c. LENGTH OF STAY IN 1b <i>1 hr.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pasadena</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>South Grindel Hosp.</i>	d. STREET ADDRESS <i>Re 5 Box 144</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>CLARA</i>	First <i>A.</i>	Middle <i>EYERLY</i>	Last <i>4</i>	4. DATE OF DEATH Month <i>4</i> Day <i>-6</i> Year <i>1967</i>		
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>81</i> <i>3-14-801</i>	9. AGE (in years last birthday) <i>86 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	11. IF UNDER 24 HRS Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife at home</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (County & State, or foreign country) <i>St Mary Co., Md. USA</i>		12. CITIZEN OF WHAT COUNTRY? <i>None</i>
13. FATHER'S NAME <i>Robert Bean</i>		14. MOTHER'S MAIDEN NAME <i>Julia Gardner</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Julia McCall - Above</i>		17. INFORMANT Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute cardiac decompensation</i> DUE TO <i>1500</i> Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>With pulmonary edema</i> DUE TO <i>generalized arteriosclerosis</i> (c) <i>several days.</i> INTERVAL BETWEEN ONSET AND DEATH						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>None</i>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Woodlawn Cem</i>	20f. (City or town) <i>Woodlawn</i>	(County) <i>Md</i>	(State)
21. I certify that (I) (this hospital) attended the deceased from <i>September 1, 1949</i> , to <i>April 6, 1967</i> , that (I) (we) last saw the deceased alive on <i>March 28, 1967</i> , and that death occurred at <i>H. A. M.</i> from the causes and on the date stated above.						
22a. SIGNATURE <i>R. M. McLaughlin</i>		22b. DATE SIGNED <i>4/6/67</i>				
22c. PHYSICIAN'S NAME (Type) <i>R. M. McLaughlin</i>		22d. ADDRESS <i>3708 Monastery Rd. Pasadena, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4-10-67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Woodlawn Cem</i>	23d. LOCATION (City, town or county) <i>Woodlawn</i>	(State) <i>Md</i>	
24. FUNERAL DIRECTOR <i>Robert S. Bananas, Sevenoak Rd.</i>		ADDRESS <i>ROBERT S. BARRANCO</i>	25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE	
			DATE APR 10 1967			

66110

66220

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #1d Film #G388 1/25/67 py CERTIFICATE OF DEATH

04556

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel County Maryland</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>30 Williams Dr. Annapolis</b>		b. COUNTY <b>A.A. County</b>	
c. LENGTH OF STAY IN lb <b>30 Williams Dr. Annapolis</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis Maryland 021</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ANNAPOULIS NURSING HOMES</b>		d. STREET ADDRESS <b>VAN BUREN 18 Bay Ridge</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>MARGARET</b>	Middle <b>Mosson</b>	4. DATE OF DEATH <b>4 - 19</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>8-9-1871</b>
9. AGE (In years last birthday) <b>95 yrs.</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Holly Springs Miss.</b>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>MAURICE MASSON</b>	14. MOTHER'S MAIDEN NAME <b>MARY Kirby</b>	Address <b>VAN BUREN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)	16. SOCIAL SECURITY NO. —	17. INFORMANT <b>ANNAPOULIS NURSING HOME Bay Ridge</b>	
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4321</b> DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>anemia</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <b>3/24/67</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>3/24/67</b>
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>3/24/67</b> to <b>4/15/67</b> , that (I) (we) last saw the deceased alive on <b>3/24/67</b> , and that death occurred at <b>4321</b> M., from causes and on the date stated above.			
22a. SIGNATURE <b>John M Taylor</b>		22b. DATE SIGNED <b>4/15/67</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>4/20/67</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>H. Lincoln</b>
23d. LOCATION (City or Town) (County) <b>Bladensburg Md.</b>			
24. FUNERAL DIRECTOR <b>John M Taylor. Sons Annapolis Md</b>		25a. REC'D. BY REGISTRAR ADDRESS <b>APR 24 1967</b>	25b. REGISTRAR'S SIGNATURE <b>John M Taylor</b>

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04555

CERTIFICATE OF DEATH

06103

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 99 and 102 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>KENTUCKY</b>		b. COUNTY <b>FAYETTE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT GEORGE G MEADE</b>		c. LENGTH OF STAY IN lb <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEXINGTON</b>		d. STREET ADDRESS <b>1719 BLUE RIDGE DRIVE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>KIMBROUGH ARMY HOSPITAL</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WARREN GOODRICH</b>		First <b>WARREN</b>	Middle <b>GOODRICH</b>	Last <b>FE</b>	4. DATE OF DEATH <b>APRIL 25</b>	Month <b>1967</b>	Day Year <b>25 19 67</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED WIDOWED <input type="checkbox"/> <b>X</b> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>30 JULY 1913</b>	9. AGE (In years last birthday) <b>53 yrs.</b>	IF UNDER 1 YEAR Months <b>53</b>	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ELECTRONICS</b>		11. BIRTHPLACE (County & State, or foreign country) <b>LUDLOW, KENTUCKY</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ELMER O. FEE</b>		14. MOTHER'S MAIDEN NAME <b>MINNIE DAVIS</b>					
15. WAS DECEASED EVER IN THE ARMY (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>14 SEPT 39-PRESENT 269-05-0689</b>		17. INFORMANT <b>PERSONNEL RECORDS ( SGT MARTIN)</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b>						INTERVAL BETWEEN ONSET AND DEATH	
H201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>KIMBROUGH AH FORT GEORGE G MEADE, MD</b>	(County) <b>Kentucky</b> (State)
21. I certify that <del>the deceased died</del> deceased <b>DOA</b> , <b>25 Apr</b> , 19 <b>67</b> , <del>from causes and on the date stated above</del> <del>xx</del> , and that death occurred at <b>3:40PM</b> from causes and on the date stated above.						22b. DATE SIGNED <b>25 April 1967</b>	
22a. SIGNATURE <i>Joseph D. Di Marco</i>		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>JOSEPH D. DI MARCO, CPT, MC</b>		22d. ADDRESS <b>KIMBROUGH AH FORT GEORGE G MEADE, MD</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>May 1, 1967</b>		23c. NAME OF CEMETERY-OR CREMATORIUM <b>Camp Nelson National Cem.</b>		23d. LOCATION (City or Town) <b>Nicholasville, Kentucky</b> (County) <b>Kentucky</b> (State)	
24. FUNERAL DIRECTOR <b>Harold S. Wade, Laurel, Maryland</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>Mar 9 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

60138

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04556

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #23b & d Film #G388 4/25/67

## Annapolis Nursing &amp; Conv. Cente 1 CERTIFICATE OF DEATH

04557

1. PLACE OF DEATH a. COUNTY Anne Arundel Co. Maryland		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel co.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	c. LENGTH OF STAY IN lb 1 Yr. 7mo.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ann apolis	d. STREET ADDRESS 115 Melvin Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Annapolis Nursing & Conv. Center		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First GEORGE	Middle H.	4. DATE OF DEATH Month 4 Doy 15 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engine man	9. DATE OF BIRTH 03/02/1889	10. KIND OF BUSINESS OR INDUSTRY	11. AGE (In years last birthday) 78 yrs.	
12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME Thomas Fitch			
14. MOTHER'S MAIDEN NAME Mary Ellen Whitehead	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown			
16. SOCIAL SECURITY NO. 218-36-8182	17. INFORMANT Rae Sadler	Address 27 ashcroft Ct. Arnold, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia &amp; Septicemia.</u> 493X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Debilitation</u> DUE TO (c) <u>Old CVA &amp; Chron. BRAINSYNDROME</u> DUE TO INTERVAL BETWEEN ONSET AND DEATH 2 weeks				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12-13</u> , 19 <u>65</u> to <u>9/15</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>4-12</u> 19 <u>67</u> , and that death occurred at <u>125PM</u> , from causes and on the date stated above.				
22a. SIGNATURE <u>Bob F. Venkouw</u>	M.D. ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22b. DATE SIGNED <u>4/15/67</u>
22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS <u>1407 FOREST DR. ANNAPOLIS.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/18/67</u>	23c. NAME OF CEMETERY OR CREMATORIUM <u>Hillcrest Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Annapolis A.A. Md.</u>	
24. FUNERAL DIRECTOR <u>T.A. Webster</u>	ADDRESS <u>Annapolis, Md.</u>	25a. REC'D BY REGISTRAR <u>APR 19 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <i>A.A. Co -</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD Anne Arundel</i> b. COUNTY <i>02101</i>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Meadowood</i>				c. LENGTH OF STAY IN 1b C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Potodorus Rd.</i>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Kingswood Manor Pt. #1-Bld 35A1 (W. Pasadena Road)</i>				d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <i>Lillian Ford</i> First <i>Lillian</i> Middle <i>Ford</i> Last <i></i>				4. DATE OF DEATH <i>4-9-67</i>									
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WOOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>April 26, 1894</i>		9. AGE (in years last birthday) <i>72 yrs.</i>		10. IF UNDER 1 YEAR Months <i></i> Days <i></i> Hours <i></i> Min. <i></i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>				11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore, Md.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Unknown Kirsch</i>				14. MOTHER'S MAIDEN NAME <i>Emma Unknown</i>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>None</i>				17. INFORMANT <i>Mr. David E. Ford (husband)</i>				Address <i>Same as #2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> <i>260X</i> DUE TO <i>A.C.V.D.</i> Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>Heart Disease well</i> DUE TO <i>Arteriosclerosis</i> (c)												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) <i></i> (County) <i></i> (State) <i></i>					
21. I certify that (I) (this hospital) attended the deceased from <i>1959 - 19</i> to <i>1967 - 19</i> , that (I) (we) last saw the deceased alive on <i>4-5-67 19</i> , and that death occurred at <i>630 M</i> , from the causes and on the date stated above.													
22a. SIGNATURE <i>Rosemary R. Johnson</i>				22b. DATE SIGNED <i>Severna Park</i>									
22c. PHYSICIAN'S NAME (Type) <i>Rosemary R. Johnson</i>				22d. ADDRESS <i>Severna Park</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>April 12, 1967</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Meadowridge Mem. Park</i>		23d. LOCATION (City, town or county) <i>Ethridge, Howard Co., Md.</i> (State) <i></i>					
24. FUNERAL DIRECTOR <i>R.V. Singleton</i>				24a. ADDRESS <i>Singleton Funeral Home</i>		25a. REC'D BY REGISTRAR <i>APR 12 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. Judge</i>					

(cont'd) 11/28/61 P.M.

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etc.

the snail

(cont'd) was

dead (cont'd)

about (cont'd) 2 weeks ago was all

the time

the snail

the snail

the snail



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

04558

**CERTIFICATE OF DEATH**

04559

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY  Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Annapolis		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frank Middle William Last FORESTELL		4. DATE OF DEATH Month April Doy 9 Year 1967	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 2, 1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  Attorney		10b. KIND OF BUSINESS OR INDUSTRY  State Comptroller	
13. FATHER'S NAME		11. BIRTHPLACE (County & State, or foreign country)  Maryland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		14. MOTHER'S MAIDEN NAME Agnes Lankum	
16. SOCIAL SECURITY NO. 415035327A		17. INFORMANT Catherine Forestell Address - Alone	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock		INTERVAL BETWEEN ONSET AND DEATH 1924	
4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO Myocardial infarction 22	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (check) attended the deceased from 4-7, 1967, to April 9, 1967, that (I) (check) last saw the deceased alive on April 9, 1967, and that death occurred at M, from causes and on the date stated above.		9:05 PM	
22o. SIGNATURE F. M. SHIPLEY		22b. DATE SIGNED 4-10-67	
22c. PHYSICIAN'S NAME (Type) F. M. SHIPLEY		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 121 Cathedral St., Annapolis, MD	
23o. BURIAL, CREMATION, REMOVAL (Specify) Burial		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill	
23b. DATE THEREOF 4-13-67		23d. LOCATION (City or Town) (County) (State) Baltimore, MD	
24. FUNERAL DIRECTOR Louis J. Banacos, Severna Park, MD		ADDRESS ROBE	
25o. RECEIVED BY REGISTRAR APR 12 1967		25b. REGISTRAR'S SIGNATURE Frances Judge	
DATE			

62340

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**04559**

**CERTIFICATE OF DEATH**

**04560**

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, at any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE				
Anne Arundel MARYLAND		Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				
c. LENGTH OF STAY IN lb						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 2055 Allen Drive				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First Eugene	Middle Junior	Last GALLOWAY	4. DATE OF DEATH APRIL 14 19 67	
S. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH September 5, 1907	9. AGE (In years lost birthday) 59 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumber Construction		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Eugene Holloway, Sr.		14. MOTHER'S MAIDEN NAME Mary Breashears		15. INFORMANT James Holloway, Jr., MD		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1538 Adenocarcinoma of colon with Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastasis (c)		DUE TO		INTERVAL BETWEEN ONSET AND DEATH Unknown		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at _____ M, from causes and on the date stated above.						
22o. SIGNATURE Ray M. Smith		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) Ray M. Smith, MD		22d. ADDRESS Hahn Prof. Bldg., Severna Park, Md.				
23o. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-18-1967	23c. NAME OF CEMETERY OR CREMATORIUM Cinnabon's Neck	23d. LOCATION (City or Town) Annapolis, Md.		
24. FUNERAL DIRECTOR William Reesett, Anna, Md.		ADDRESS	25o. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE	
			DATE APR 17 1967			

Open

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

04560

**CERTIFICATE OF DEATH**

04561

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE	
Anne Arundel MARYLAND		Maryland Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	
Annapolis			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Anne Arundel Gen. Hospt.			
f. STREET ADDRESS		d. DATE OF DEATH	
607 Burnside St.		APRIL 20 1967	
g. DATE OF DEATH		Month Doy Year	
APRIL 20 1967		Month Doy Year	
h. NAME OF DECEASED (Type or print)		i. FIRST MIDDLE LAST	
BESSIE ROBERTA GARTHE			
j. SEX		k. COLOR OR RACE	
F		W	
l. MARRIED WIDOWED		m. NEVER MARRIED DIVORCED	
Widowed		<input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>	
n. DATE OF BIRTH		o. AGE (In years 1st birthday) yrs.	
Nov 16 1895		71 yrs.	
p. IF UNDER 1 YEAR Months Days Hours Min.		q. IF UNDER 24 HRS. Months Days Hours Min.	
r. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		s. KIND OF BUSINESS OR INDUSTRY	
Housewife		Name	
t. BIRTHPLACE (County & State, or foreign country)		u. CITIZEN OF WHAT COUNTRY?	
ANNAPOLIS		US	
v. FATHER'S NAME		w. MOTHER'S MAIDEN NAME	
Julius H. Finkle		Annie May Riley	
x. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)		y. SOCIAL SECURITY NO.	
No			
z. INFORMANT		aa. ADDRESS	
Mr. Harry Louis Gartke #2			
bb. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)		cc. INTERVAL BETWEEN ONSET AND DEATH	
Carcinoma of the Colon		Unknown	
dd. DUE TO		ee. DUE TO	
1538			
ff. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (o), STATING THE UNDERLYING CAUSE LAST		gg. DUE TO	
hh. DUE TO		ii. DUE TO	
jj. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		kk. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ll. MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		mm. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
nn. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		oo. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
pp. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		qq. (City or town) (County) (State)	
rr. 21. I certify that (I) (His hospital) attended the deceased from _____, 1967, to 4/20/1967, that (I) (we) last saw the deceased alive on 4/19/1967, and that death occurred at 2:10 AM, from causes and on the date stated above.		ss. DATE SIGNED 4/20/1967	
tt. 22. SIGNATURE Richard I. Hochman		uu. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
vv. 22c. PHYSICIAN'S NAME (Type) Richard I. Hochman, MD		ww. ADDRESS 59 Franklin St., Annapolis, Md.	
xx. 23a. BURIAL, CREMATION, REMOVAL (Specify)		yy. 23b. DATE THEREOF 4-24-1967	
Burial		Mt Olivet Cem.	
zz. 23c. NAME OF CEMETERY OR CREMATORIAL		aa. 23d. LOCATION (City or Town) (County) (State) Maspeth Queens NY	
bb. 24. FUNERAL DIRECTOR JOHN M TAYLOR Sons Annapolis MD.		cc. 25. ADDRESS DTPR 24 1967	
dd. 25b. REGISTRAR'S SIGNATURE Charles Judge		ee. 25c. REC'D BY REGISTRAR	

1720

3210

Digitized by srujanika@gmail.com

22. 1972. 1973. 1974. 1975. 1976. 1977. 1978. 1979. 1980. 1981. 1982. 1983. 1984. 1985. 1986. 1987. 1988. 1989. 1990. 1991. 1992. 1993. 1994. 1995. 1996. 1997. 1998. 1999. 2000. 2001. 2002. 2003. 2004. 2005. 2006. 2007. 2008. 2009. 2010. 2011. 2012. 2013. 2014. 2015. 2016. 2017. 2018. 2019. 2020. 2021. 2022. 2023. 2024. 2025. 2026. 2027. 2028. 2029. 2030. 2031. 2032. 2033. 2034. 2035. 2036. 2037. 2038. 2039. 2040. 2041. 2042. 2043. 2044. 2045. 2046. 2047. 2048. 2049. 2050. 2051. 2052. 2053. 2054. 2055. 2056. 2057. 2058. 2059. 2060. 2061. 2062. 2063. 2064. 2065. 2066. 2067. 2068. 2069. 2070. 2071. 2072. 2073. 2074. 2075. 2076. 2077. 2078. 2079. 2080. 2081. 2082. 2083. 2084. 2085. 2086. 2087. 2088. 2089. 2090. 2091. 2092. 2093. 2094. 2095. 2096. 2097. 2098. 2099. 20100.

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ON 24334 D 1979 M3 T3V1-074 1381-45-4 JA1979

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

04561

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04562

|  |                       |   |                           |   |  |   |                               |            |           |
|--|-----------------------|---|---------------------------|---|--|---|-------------------------------|------------|-----------|
| 1. PLACE OF DEATH<br>a. COUNTY<br>A. A. CO.  |                       | MARYLAND  |                           | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br>Maryland |  | b. COUNTY<br>A. A. CO.  |                               |            |           |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Annapolis  |                       | c. LENGTH OF STAY IN TB   |                           | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>MAYO                      |  |   |                               |            |           |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>D.O.A.-ANNE ARUNDEL-GENERAL  |                       | d. STREET ADDRESS   |                           | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |   |                               |            |           |
| 3. NAME OF<br>DECEASED<br>(Type or print)  |                       | First<br>George   | Middle<br>13              | Lost<br>Giddings St   | 4. DATE<br>OF<br>DEATH<br>4              | Month<br>8  | Doy<br>19                     | Year<br>67 |           |
| S. SEX<br>M  | 6. COLOR OR RACE<br>W | 7. MARRIED<br>WIDOWED   | NEVER MARRIED<br>DIVORCED | 8. DATE OF BIRTH<br>5-5-24  | 9. AGE (In years<br>last birthday)<br>42 | IF UNDER 1 YEAR<br>Months<br>0  | IF UNDER 24 HRS.<br>Days<br>0 | Hours<br>0 | Min.<br>0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Carpenter   |                       | 10b. KIND OF BUSINESS OR INDUSTRY<br>Building   |                           | 11. BIRTHPLACE (State or foreign country)<br>Md   |  | 12. CITIZEN OF WHAT COUNTRY<br>USA                                      |                               |            |           |
| 13. FATHER'S NAME<br>George Giddings, SR   |                       | 14. MOTHER'S MAIDEN NAME<br>Eugenia T. Giddings   |                           |   |  |   |                               |            |           |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br>Yes WW II  |                       | 16. SOCIAL SECURITY NO.<br>577 28 7870  |                           | 17. INFORMANT<br>Eugenia T. Giddings Beltsville Md.   |  | Address   |                               |            |           |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>4344   |                       | DUE TO<br>Conditions, if any, which gave rise to immediate cause (a).<br>stating the underlying cause<br>lost.<br>(b) |                           | DUE TO<br>(c)   |  | INTERVAL BETWEEN ONSET AND DEATH<br>Rusher                              |                               |            |           |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)   |                       |   |                           |   |  |   |                               |            |           |
| 20a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH.  |                       | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                          |                           | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |   |                               |            |           |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m.<br>p.m. 19   |                       | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>             |                           | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                    |                               |            |           |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                       |   |                           |   |  |   |                               |            |           |
| ACTUAL<br>SIGNATURE<br><i>E. Linhardt</i>  |                       | M.D.  |                           | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | 22. DATE SIGNED<br>4-5-67   |                               |            |           |
| EXAMINER'S<br>NAME (Type)<br>E. Linhardt   |                       | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |                           | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  | Address (Street, city, town, or county)                                 |                               |            |           |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |                       | 23b. DATE THEREOF<br>April 12, 1967   |                           | 23c. NAME OF CEMETERY OR CREMATORIAL<br>St John's Cemetery  |  | 23d. LOCATION (City or Town) (County) (State)<br>Beltsville Pro Geo Md. |                               |            |           |
| 24. FUNERAL DIRECTOR<br>F. Gasch's Sons  |                       | ADDRESS<br>Hyattsville, Md.   |                           | 25a. REC'D BY REGISTRAR<br>APR 12 1967  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Juges</i>                      |                               |            |           |

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04562

## CERTIFICATE OF DEATH

04563

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

|  |  |  |  |  |  |   |                          |              |
|--|--|--|--|--|--|---|--------------------------|--------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br>AA Co  |  | MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE Md |  | b. COUNTY AA Co   |                          |              |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Brooklyn   |  | c. LENGTH OF STAY IN 1b  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Brooklyn         |  | d. STREET ADDRESS<br>5513 Magie St Balto, Md 21225  |                          |              |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br>5513 Magie St Balto, Md 21225  |  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |  |   |                          |              |
| 3. NAME OF DECEASED (Type or print)<br>Mae   |  | First  | Middle   | Last   | 4. DATE OF DEATH<br>Apr 26                 | Month   | Dey                      | Year<br>1967 |
| 5. SEX<br>Female   |  | 6. COLOR OR RACE<br>W  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | B. DATE OF BIRTH<br>Mar. 9, 1893   | 9. AGE (In years last birthday)<br>74 yrs. | IF UNDER 1 YEAR<br>Months   | IF UNDER 24 HRS.<br>Days | Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (County & State, or foreign country)<br>Md  |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA   |                          |              |
| 13. FATHER'S NAME<br>Dorsey  |  | 14. MOTHER'S MAIDEN NAME<br>Harmon Addie Phelps  |  |  |  |   |                          |              |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No   |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>Family  |  | Address<br>Same   |                          |              |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)   |  | DUE TO<br>260X<br>Conditions, if any, which<br>give rise to immediate cause<br>(a), stating the underlying<br>cause last.                                |  | Pulmonary Edema  |  | INTERVAL BETWEEN<br>ONSET AND DEATH   |                          |              |
| { (b) DUE TO   |  | { (c) DUE TO   |  | ASC VHD - Congestive Heart Failure   |  |   |                          |              |
| { (c) DUE TO   |  | { (c) DUE TO   |  | Debile condition   |  |   |                          |              |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |  |  |  |  |   |                          |              |
| 20c. MEDICAL CERTIFICATION   |  | 20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner) |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)         |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                          |              |
| 20c. TIME OF INJURY<br>Hour e.m.<br>p.m.   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                               |  | 20f. (City or town) (County) (State)  |                          |              |
| 19   |  |  |  |  |  |   |                          |              |
| 21. I certify that (1) (this hospital) attended the deceased from 4/24/67, 19....., to 4/26/67, 19....., that (1) (we) last saw the deceased alive on 4/24/67, 19....., and that death occurred at 9A.M. from the causes and on the date stated above. |  |  |  |  |  |   |                          |              |
| 22e. SIGNATURE<br>Andrew R. Sosnowski  |  | M.D.   |  | ATTENDING PHYS. <input checked="" type="checkbox"/>  |  | 22b. DATE SIGNED<br>MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |                          |              |
| 22c. PHYSICIAN'S NAME (Type)<br>Andrew R. Sosnowski  |  |  |  | 22d. ADDRESS<br>4016 Ritchie Hwy Balto 25 Md   |  |   |                          |              |
| 23e. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 23b. DATE THEREOF<br>4/29/67   |  | 23c. NAME OF CEMETERY OR CREMATORIUM<br>Cedar Hill Cem   |  | 23d. LOCATION (City, town or county) (State)<br>AA CO   |                          |              |
| 24 FUNERAL DIRECTOR'S SIGNATURE<br>McCully F H 237 Patapsco Ave 21225  |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR<br>DATE APR 28 1967  |  | 25b. REGISTRAR'S SIGNATURE<br>jCharles Judge  |                          |              |

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

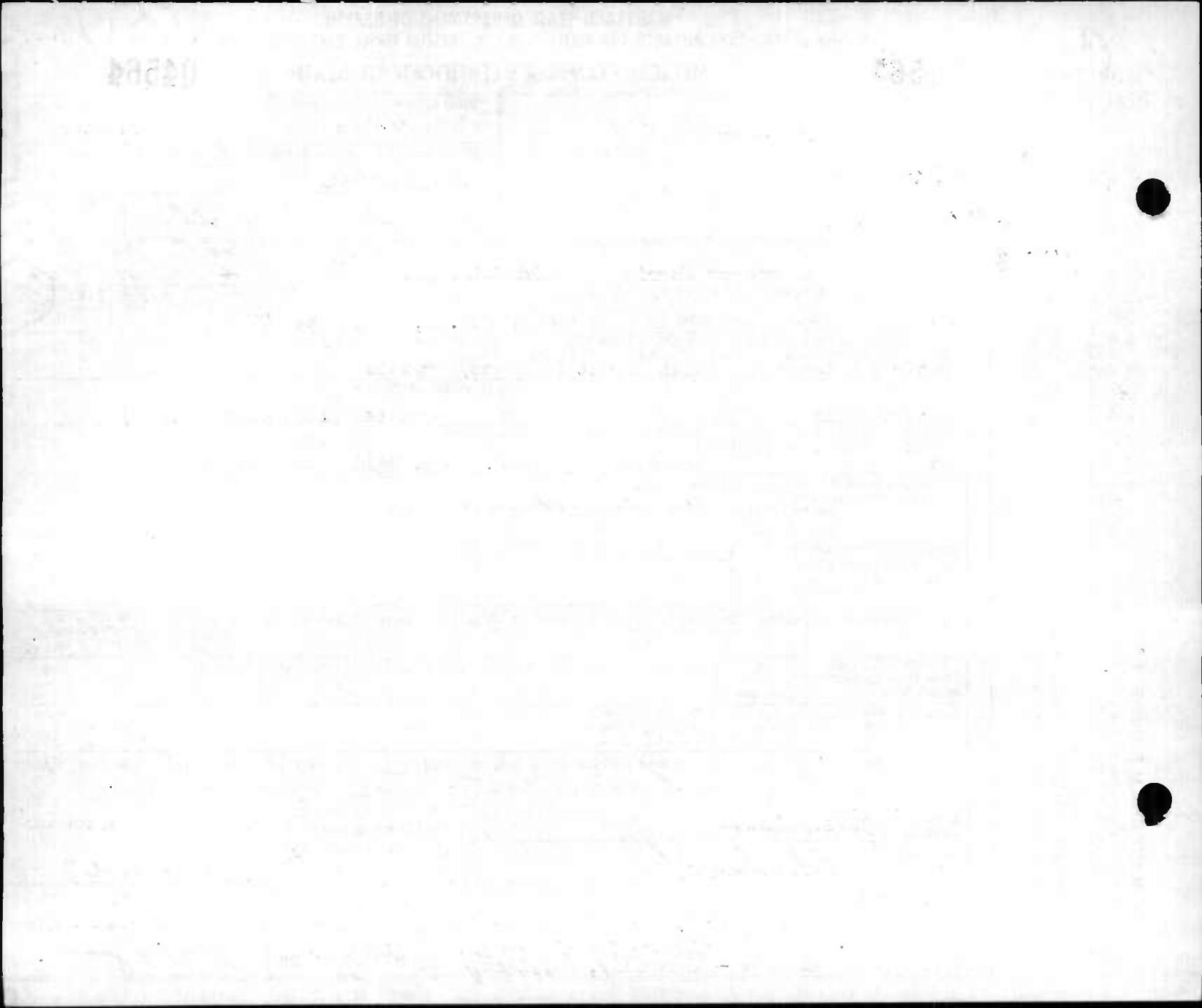
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**04563**

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**04564**

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><i>Anne Arundel Co</i>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MASS.</b>   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>   |  | b. COUNTY <b>Worcester</b>   |   |
| c. LENGTH OF STAY IN 1b  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>worcester</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>D.O.H.-Anne</b>   |  | d. STREET ADDRESS<br><b>575 Salisbury St.</b>  |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |   |
| 3. NAME OF DECEASED<br>(Type or print)   |  | First <b>Gold</b>  | Middle <b>Morris</b>  |
| 4. DATE OF DEATH<br><b>Jan. 1, 1890</b>  |  | Month <b>4</b>   | Day <b>21</b>   |
| 5. SEX <b>M</b>  |  | 6. COLOR OR RACE <b>W</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH<br><b>Jan. 1, 1890</b>  |  | 9. AGE (In years lost birthday) <b>77 yrs.</b>   | 10. IF UNDER 1 YEAR<br>Months <b>0</b> Dows <b>0</b> Hours <b>0</b> Min. <b>0</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>retired butcher</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Meat Market (own business)</b>   | 11. BIRTHPLACE (State or foreign country)<br><b>Russia</b>  |
| 13. FATHER'S NAME<br><b>Joseph Gold</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Minnie (last name unknown)</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>no</b>   |  | 16. SOCIAL SECURITY NO.<br><b>unknown</b>  | 17. INFORMANT<br>Address<br><b>Mrs. Sarah Gold same as #2 above</b>   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma</b> DUE TO <b>old age</b> INTERVAL BETWEEN ONSET AND DEATH <b>old age</b><br>4321<br>Conditions, if any, which gave rise to immediate cause (a),<br>stating the underlying cause (b) DUE TO <b>old age</b><br>lost (c) DUE TO <b>old age</b>   |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)   |  |  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. <b>19</b>  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/>  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)   |
| 20f. (City or town) <b>Worcester</b> (County) <b>Mass.</b> (State) <b>Mass.</b>  |  |  |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |   |
| ACTUAL SIGNATURE <i>Worcester</i>  |  | M.D.   |   |
| EXAMINER'S NAME (Type) <i>F.L. Shadoff</i>   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county) <b>Worcester, Mass.</b> |   |
| 23a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>  |  | 23b. DATE THEREOF <b>April 23, 1967</b>  |   |
| 23c. NAME OF CEMETERY OR CREMATORIAL <b>Hebrew Cemetery</b>  |  | 23d. LOCATION (City or Town) <b>Worcester</b> (County) <b>Mass.</b> (State) <b>Mass.</b>   |   |
| 23e. FUNERAL DIRECTOR <b>E. Hopping</b> ADDRESS <b>Bentley &amp; Hopping</b><br>Hopping Funeral Home - Annapolis, Maryland   |  | 23f. REC'D BY REGISTRAR <b>APR 24 1967</b> 23g. REGISTRAR'S SIGNATURE <i>Charles Judge</i>   |   |



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04565

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send carbon papers, Pages 1 and 2, to the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |  |  |   |  |   |  |   |  |
|---|--|--|---|--|---|--|---|--|
| 1<br>04564  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)   |  |   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>ANNE ARUNDEL</b>   |  |  | b. STATE<br><b>MARYLAND</b>   |  |   |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>FORT GEO G MEADE</b>   |  |  | c. LENGTH OF STAY IN 1b<br><b>1 DAY</b>   |  |   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>KIMBROUGH ARMY HOSPITAL</b>  |  |  | e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>SEVERNA PARK</b>                         |  |   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>WALTER RAYMOND GRAALMAN</b>  |  |  | f. STREET ADDRESS<br><b>302 ST IVES DRIVE</b>   |  |   |  |   |  |
| 4. DATE OF DEATH<br><b>APRIL 25 1967</b>  |  |  | g. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               |  |   |  |   |  |
| 5. SEX<br><b>MALE</b>   |  |  | 6. COLOR OR RACE<br><b>CAU</b>  |  |   |  |   |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>   |  |  | 8. DATE OF BIRTH<br><b>9 NOV 1905</b>   |  |   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>DIRECT OF MATERIEL</b>  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>MARTIN MARIETTA</b>   |  |   |  |   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>OKEENE, OKLAHOMA</b>  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |   |  |   |  |
| 13. FATHER'S NAME<br><b>EDWARD W. GRAALMAN</b>  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>SARA GEIS</b>  |  |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/><br><b>YES</b>   |  |  | 16. SOCIAL SECURITY NO.<br><b>APR 42-DEC 60 561-54-7408</b>   |  |   |  |   |  |
| 17. INFORMANT<br><b>ODELL, EDWARD N.</b>  |  |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]   |  |   |  |   |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b>  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>36 hours</b>   |  |   |  |   |  |
| Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.<br>(b)<br>(c)  |  |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                    |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Hour a.m. <b>19</b><br>p.m.  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>                       |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>20f. (City or town) (County) (State)</b> |  |   |  |
| 21. I certify that (X) (this hospital) attended the deceased from <b>24 April 1967</b> to <b>25 April 1967</b> , that (X) (we) last saw the deceased alive on <b>25 April 1967</b> , and that death occurred at <b>10:22 PM</b> from the causes and on the date stated above. |  |  | 22b. DATE SIGNED<br><b>25 April 1967</b>  |  |   |  |   |  |
| 22e. SIGNATURE<br><i>Jorge J. Ramirez</i>   |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  |   |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>JORGE J. RAMIREZ, CPT, MC</b>  |  |  | 22d. ADDRESS<br><b>KIMBROUGH AH FORT GEORGE G. MEADE, MD</b>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |  | 23b. DATE THEREOF<br><b>4-28-67</b>   |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>Arlington National Cemetery</b>  |  | 23d. LOCATION (City, town or county)<br><b>Arlington, Va.</b> |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><i>Robert S. Barranco, severna Pk, Md</i>   |  |  | 25a. REC'D BY REGISTRAR<br><b>MAY 1 1967</b>  |  |   |  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |  |   |  |   |  |   |  |

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04565

## CERTIFICATE OF DEATH

04566

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |                        |  |   |
|---|------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY Anne Arundel MARYLAND  |                        | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE Maryland b. COUNTY Anne Arundel  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville  |                        | c. LENGTH OF STAY IN lb lyr. 5mos.   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital   |                        | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED First Mattie Middle L. Green  |                        | 4. DATE OF DEATH Month 4 Day 25 Year 19 67   |   |
| S. SEX Female   | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br><input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH 2/6/82   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown   |                        | 11. BIRTHPLACE (County & State, or foreign country) Maryland   |   |
| 13. FATHER'S NAME William Ogle  |                        | 14. MOTHER'S MAIDEN NAME Lena  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No  |                        | 16. SOCIAL SECURITY NO. 217-34-4194  |   |
| 17. INFORMANT Hospital Records  |                        | Address  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (o) Anemia<br>733X<br>DUE TO Osteoporosis<br>Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b)<br>DUE TO Senility (c) |                        |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)<br>CBS due Generalized and Cerebral Arteriosclerosis. Recubitus Divers   |                        |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                        | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>-----  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. 17   |                        | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/>                          | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>----- |
| 21. I certify that (I) (this hospital) attended the deceased from 11/30/1965 to 4/25/1967, that (I) (we) last saw the deceased alive on 4/25/1967, and that death occurred at 9:15 M, from causes and on the date stated above.   |                        | 20f. (City or town) (County) (State)<br>-----  |   |
| 22a. SIGNATURE Lionel McHenry Mapp  |                        | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/><br>MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  | 22b. DATE SIGNED 4/25/67  |
| 22c. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M.D.  |                        | 22d. ADDRESS Crownsville State Hospital, Md.   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial  |                        | 23b. DATE THEREOF 4-27-67  | 23c. NAME OF CEMETERY OR CREMATORIAL New Cathedral Cem                          |
| 24. FUNERAL DIRECTOR Thomas J Kenny Inc 1600 Hollins St   |                        | ADDRESS  | 25a. REC'D BY REGISTRAR   |
|   |                        |  | 25b. REGISTRAR'S SIGNATURE APR 26 1967 Charles J. George                        |

POSTAL PATRONAGE REPORT FOR THE MONTH OF JUNE 1944

03280

03280

STATIONERY - PAPER - ENVELOPES - CARDS - STAMPS - ETC.

BOOKS - MAGAZINES - NEWSPAPERS - PICTURES - ETC.

COINS - STAMPS - MEDALS - ETC.

TELEGRAMS - TELEPHONES - TELETYPE - ETC.

POSTAL PATRONAGE REPORT FOR THE MONTH OF JUNE 1944

STATIONERY - PAPER - ENVELOPES - CARDS - STAMPS - ETC.

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POSTAL PATRONAGE REPORT FOR THE MONTH OF JUNE 1944

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POSTAL PATRONAGE REPORT FOR THE MONTH OF JUNE 1944

STATIONERY - PAPER - ENVELOPES - CARDS - STAMPS - ETC.

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TELEGRAMS - TELEPHONES - TELETYPE - ETC.

POSTAL PATRONAGE REPORT FOR THE MONTH OF JUNE 1944

STATIONERY - PAPER - ENVELOPES - CARDS - STAMPS - ETC.

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COINS - STAMPS - MEDALS - ETC.

TELEGRAMS - TELEPHONES - TELETYPE - ETC.

POSTAL PATRONAGE REPORT FOR THE MONTH OF JUNE 1944

*25*  
1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

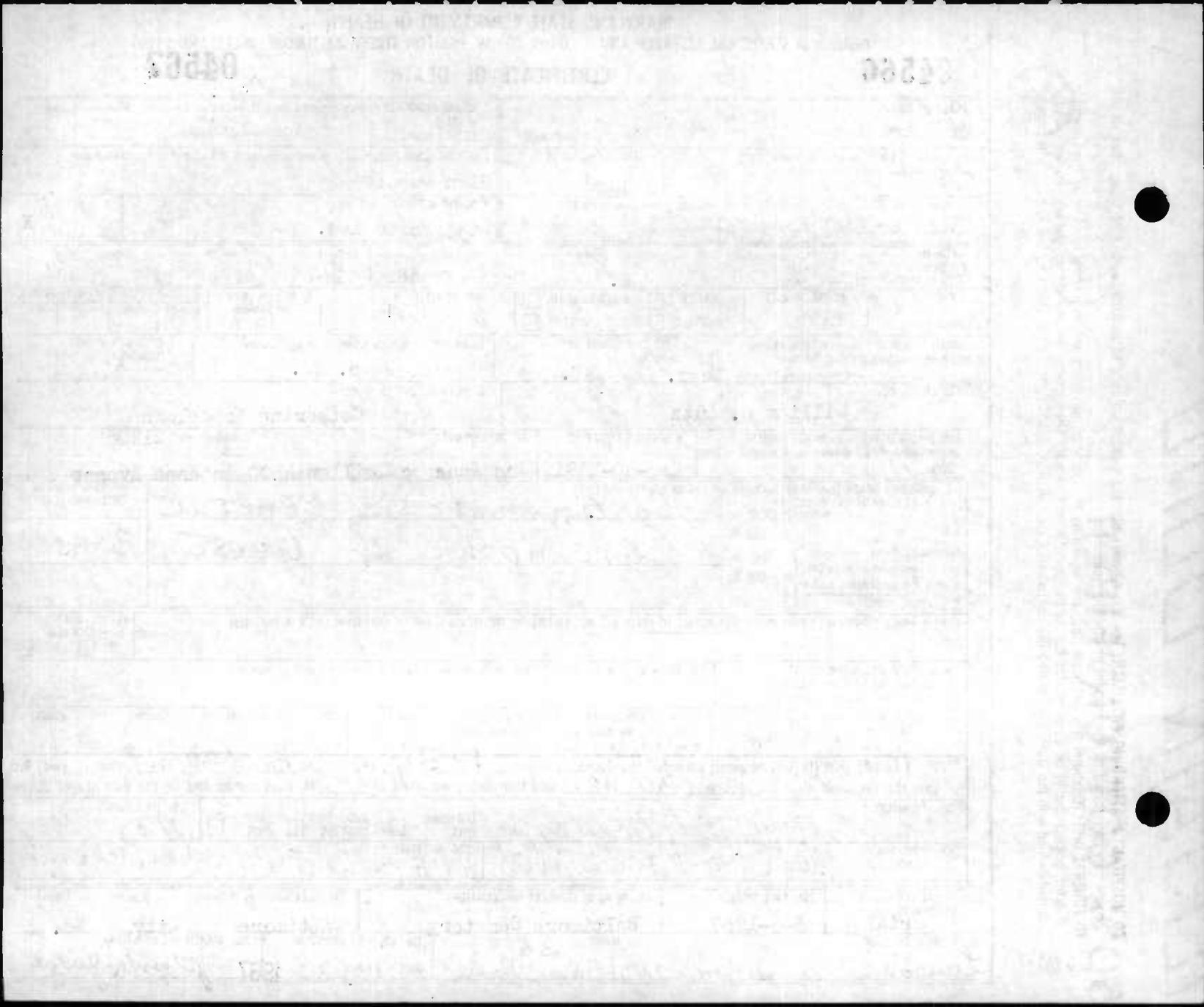
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04566

## CERTIFICATE OF DEATH

04567

|   |                           |  |  |  |   |   |                                   |
|---|---------------------------|--|--|--|---|---|-----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Anne Arundel<br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Glen Burnie   |                           | c. LENGTH OF STAY IN lb<br>9 days  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br>Maryland<br>b. COUNTY<br>Anne Arundel |   |   |                                   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>North Arundel Hospital  |                           |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Glen Burnie  |   |   |                                   |
| d. STREET ADDRESS<br>133 Marie Ave.   |                           |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |   |                                   |
| 3. NAME OF DECEASED<br>(Type or print)<br>Margaret  |                           | First<br>A.  | Middle<br>Greensfelder                             | 4. DATE OF DEATH<br>April 30 1967  | Month<br>Doy<br>Year                          |   |                                   |
| S. SEX<br>Female  | 6. COLOR OR RACE<br>White | 7. MARRIED<br>WIDOWED <input checked="" type="checkbox"/>  | NEVER MARRIED<br>DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>3/28/1891  | 9. AGE (In years<br>lost birthday)<br>76 yrs. | IF UNDER 1 YEAR<br>Months<br>Days                                   | IF UNDER 24 HRS.<br>Hours<br>Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Baltimore City Police Dept. Law enf.   |                           | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (County & State, or foreign country)<br>Baltimore Co. Md.   |   | 12. CITIZEN OF WHAT COUNTRY?<br>USA                                 |                                   |
| 13. FATHER'S NAME<br>William H. Lutz  |                           |  |  | 14. MOTHER'S MAIDEN NAME<br>Catherine Koppelman  |   |   |                                   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br>No  |                           | 16. SOCIAL SECURITY NO.<br>216-40-2191   |  | 17. INFORMANT<br>Mrs Anna Mc Quillen 4400 Antanna Avenue   |   | Address<br>21206  |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (o)<br><i>170X</i>   |                           | DUE TO<br>(b)  |  | <i>Carcinomatosis General<br/>Carcinoma of Breast</i>  |   | INTERVAL BETWEEN ONSET AND DEATH<br>3 yrs                           |                                   |
| Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost.  |                           | DUE TO<br>(c)  |  |  |   |   |                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)  |                           |  |  |  |   |   |                                   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |   |   |                                   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m.<br>p.m. 19  |                           | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)                                |                                   |
| 21. I certify that (I) (this hospital) attended the deceased from <i>1964</i> , 19, to <i>April 30</i> , 1967, that (I) (we) last saw the deceased alive on <i>April 30</i> , 1967, and that death occurred at <i>530 p.m.</i> M, from causes and on the date stated above. |                           |  |  |  |   |   |                                   |
| 22a. SIGNATURE<br><i>Joseph Taler, M.D.</i>   |                           | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                                |  | 22b. DATE SIGNED<br><i>May 1, 1967</i>   |   |   |                                   |
| 22c. PHYSICIAN'S NAME (Type)<br>JOSEPH TALER, M.D.  |                           | 22d. ADDRESS<br><i>45 Aquahart Rd. Glen Burnie, Md.</i>  |  |  |   |   |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |                           | 23b. DATE THEREOF<br>5-3-1967  |  | 23c. NAME OF CEMETERY OR CREMATORIUM<br>Baltimore Cemetery   |   | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore City Md. |                                   |
| 24. FUNERAL DIRECTOR<br><i>Lassahn Funeral Home 740 Belair Road</i>   |                           | ADDRESS<br>36  |  | 25a. REC'D BY REGISTRAR<br>Charles Judge   |   | 25b. REGISTRAR'S SIGNATURE  |                                   |
|   |                           |  |  | DATE MAY 3 1967  |   |   |                                   |



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |  |  |                      |  |   |   |                        |  |  |  |
|--|--|--|--|----------------------|--|---|---|------------------------|--|--|--|
| CERTIFICATE OF DEATH   |  |  |  |                      |  |   |   |                        |  |  |  |
| 04567  |  |  | Item #9 Film #0388 4/25/67 pc  |                      |  | 04568   |   |                        |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY Anne Arundel  |  |  | MARYLAND   |                      |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE Maryland                      |   |                        |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie 7355 Fur. Br. Rd.   |  |  | c. LENGTH OF STAY IN lb 5 yrs  |                      |  | b. COUNTY Balto. City   |   |                        |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Plaza Manor Inc. 7355 Fur. Br. Rd.  |  |  |  |                      |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore                                      |   |                        |  |  |  |
| 3. NAME OF DECEASED (Type or print) William  |  |  | First  | Middle               | Last                                   | 4. DATE OF DEATH  | Month                                       | Day                    | Year   |  |  |
| 5. SEX Male  |  |  | 6. COLOR OR RACE White   | 7. MARRIED Separated | NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH May 18, 1896   | 9. AGE (In years last birthday) 70 1/2 yrs. | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Hours   |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |                      |  | 11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.  |   |                        | 12. CITIZEN OF WHAT COUNTRY? United States                               |  |  |
| 13. FATHER'S NAME Unknown  |  |  | 14. MOTHER'S MAIDEN NAME Wright  |                      |  |   |   |                        |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No   |  |  | 16. SOCIAL SECURITY NO. 219-05-1584  |                      |  | 17. INFORMANT Patients Chart  |   |                        | Address  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)  |  |  |  |                      |  |   |   |                        | INTERVAL BETWEEN ONSET AND DEATH   |  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac Arrest   |  |  |  |                      |  |   |   |                        | Tmm.   |  |  |
| 241X<br>Conditions, if any, which<br>give rise to immediate cause<br>(a), stating the underlying<br>cause last.  |  |  | (b) Chronic Pulmonary Congestion 2ndary to<br>DUE TO Bronchial Asthma                        |                      |  |   |   |                        | Sev. Days  |  |  |
|  |  |  | (c) Senility   |                      |  |   |   |                        | Sev. Mrs.  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)   |  |  |  |                      |  |   |   |                        | 19. WAS AUTOPSY PERFORMED?   |  |  |
| 20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) |                      |  |   |   |                        | YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. 20d. INJURY OCCURRED<br>p.m. 19 While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>  |  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                       |                      |  | 20f. (City or town) (County) (State)  |   |                        |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from July 27, 1962 to April 12, 1967, that (I) (we) last saw the deceased alive on April 11, 1967, and that death occurred at 2:45 PM from the causes and on the date stated above. |  |  |  |                      |  |   |   |                        |  |  |  |
| 22e. SIGNATURE Richard H. Hunt   |  |  | M.D.   |                      |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   |                        | April 12, 1967<br>22b. DATE SIGNED                                       |  |  |
| 22c. PHYSICIAN'S NAME (Type) Richard H. Hunt   |  |  |  |                      |  | 22d. ADDRESS 100 Cherry Lane, Glen Burnie, Md.  |   |                        |  |  |  |
| 23e. BURIAL, CREMATION, REMOVAL (Specify) Burial   |  |  | 23b. DATE THEREOF 4-14-1967  |                      |  | 23c. NAME OF CEMETERY OR CREMATORIAL Glen Haven Memorial Pk.  |   |                        | 23d. LOCATION (City, town or county) Ritchie Hwy., A.A.C.O., Md. (State) |  |  |
| 24 FUNERAL DIRECTOR'S SIGNATURE George J. Gonce-4001 Ritchie Hwy., Baltimore   |  |  | ADDRESS  |                      |  | 25e. REC'D BY REGISTRAR APR 17 1967   |   |                        | 25b. REGISTRAR'S SIGNATURE Charles Judge                                 |  |  |
| VR A15 (4)<br>2DM 5-63   |  |  |  |                      |  |   |   |                        |  |  |  |

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04568

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04569

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |                              |   |   |  |  |   |                                      |                   |                  |
|---|------------------------------|---|---|--|--|---|--------------------------------------|-------------------|------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><i>AA CO.</i>   |                              | MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><i>MD</i> |  | b. COUNTY<br><i>AA CO.</i>  |                                      |                   |                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>NARROWS</i>  |                              | c. LENGTH OF STAY IN 1b   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>NARROWS</i>             |  | d. STREET ADDRESS<br><i>P.O.</i>                                  |                                      |                   |                  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  |                              |   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>              |  |   |                                      |                   |                  |
| 3. NAME OF<br>DECEASED<br>(Type or print)   |                              | First<br><i>CARVEL</i>  | Middle<br><i>W.</i>                                   | Lost<br><i>griffith</i>  | 4. DATE<br>OF<br>DEATH<br><i>4</i>                   | Month<br><i>6</i>   | Day<br><i>19</i>                     | Year<br><i>67</i> |                  |
| S. SEX<br><i>M</i>  | 6. COLOR OR RACE<br><i>W</i> | 7. MARRIED<br>WIDOWED<br><input type="checkbox"/>   | NEVER MARRIED<br>DIVORCED<br><input type="checkbox"/> | B. DATE OF BIRTH<br><i>18 Nov 1915</i>   | 9. AGE (In years<br>lost birthday)<br><i>51 yrs.</i> | IF UNDER 1 YEAR<br>Months<br><i>0</i>                             | IF UNDER 24 HRS.<br>Days<br><i>0</i> | Hours<br><i>0</i> | Min.<br><i>0</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>nursery Dept.</i>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>Md. State Forestry Dept.</i>                                      |   | 11. BIRTHPLACE (State or foreign country)<br><i>Severn, Maryland</i>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                     |                                      |                   |                  |
| 13. FATHER'S NAME<br><i>Robert Griffith</i>   |                              | 14. MOTHER'S MAIDEN NAME<br><i>Ide M. Boyer</i>   |   | Address<br><i>Severn, Md.</i>  |  |   |                                      |                   |                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><i>yes</i>  |                              | 16. SOCIAL SECURITY NO.<br><i>77-07-6901</i>  |   | 17. INFORMANT<br><i>Leonard M. Griffith ret 3-BX159</i>  |  |   |                                      |                   |                  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (o)<br><i>4394</i>  |                              | DUE TO<br><i>Cardiac disease</i>  |   | INTERVAL BETWEEN ONSET AND DEATH<br><i>udden</i>   |  |   |                                      |                   |                  |
| Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause<br><i>due to</i><br><i>lost.</i>   |                              | (b)<br><i></i>  |   | (c)<br><i></i>   |  |   |                                      |                   |                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)  |                              |   |   |  |  |   |                                      |                   |                  |
| 20a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH.   |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |   |  |  |   |                                      |                   |                  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m.<br>p.m.<br><i>19</i>  |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                              |                                      |                   |                  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                              |   |   |  |  |   |                                      |                   |                  |
| ACTUAL<br>SIGNATURE<br><i>E. Lubinoff</i>   |                              | M.D.  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   |                                      |                   |                  |
| EXAMINER'S<br>NAME (Type)<br><i>E. Lubinoff</i>   |                              | M.D.  |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |   |                                      |                   |                  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><i>Burial</i>   |                              | 23b. DATE THEREOF<br><i>4/10/67</i>   |   | 23c. NAME OF CEMETERY OR CREMATORIAL<br><i>Balto. Nat'l. Cemetery</i>  |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Baltimore</i> |                                      |                   |                  |
| 24. FUNERAL DIRECTOR<br><i>Robert Savage</i>  |                              | ADDRESS<br><i>Singleton Funeral Home - Glen Burnie, Md.</i>   |   | 25a. RECEIVED BY REGISTRAR<br><i>APR 10 1967</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                |                                      |                   |                  |

8320

1943-1944

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1943-1944

**1**  
**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4** may be retained by the hospital or attending physician.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04563

**CERTIFICATE OF DEATH**

04570

|  |                                  |   |  |  |  |   |  |                  |
|--|----------------------------------|---|--|--|--|---|--|------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b>  |                                  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> |  |  |   |  |                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Glen Burnie</b>   |                                  | c. LENGTH OF STAY IN lb<br><b>hrs.</b>  |  | b. COUNTY<br><b>Anne Arundel</b>                                   |  |   |  |                  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>North Arundel Gen. Hosp.</b>  |                                  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Orchard Beach</b>             |  |  |   |  |                  |
| d. STREET ADDRESS<br><b>7917 East End Drive</b>  |                                  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |  |  |   |  |                  |
| 3. NAME OF<br>DECEASED<br>(Type or print)  | First<br><b>ERNESTINE</b>        | Middle<br><b>K.</b>   | Last<br><b>HAAS</b>  | 4. DATE<br>OF<br>DEATH<br><b>April 6,</b>                          | Month<br><b>1967</b>   |   |  |                  |
| S. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Jan. 15, 1892</b>   | 9. AGE (In years<br>last birthday)<br><b>75 yrs.</b>               | IF UNDER 1 YEAR<br>Months<br><b>0</b>                                  | IF UNDER 24 HRS.<br>Days<br><b>0</b>  | Hours<br><b>0</b>                                  | Min.<br><b>0</b> |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br><b>Housewife</b>   |                                  |   | 10b. KIND OF BUSINESS OR<br>INDUSTRY   |  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Chicago, Ill.</b> |  |                  |
| 13. FATHER'S NAME<br><b>David R. Van Brunt</b>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Jennie McCann</b>   |  |  | 12. CITIZEN OF WHAT<br>COUNTRY?<br><b>U.S.</b>                              |  |                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>  |                                  |   | 16. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT<br><b>Mr. Wm. H. Haas 7917 East End Drive</b>                 |  |                  |
| Address  |                                  |   |  |  |  |   |  |                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>200X</b><br>DUE TO<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. (b)<br>DUE TO<br>(c)<br>DUE TO<br><b>Coronary thrombosis</b><br><b>Autonomic cardiovascular disease</b><br><b>Diabetes mellitus</b> |                                  |   |  |  |  |   |  |                  |
| INTERVAL BETWEEN<br>ONSET AND DEATH  |                                  |   |  |  |  |   |  |                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                                  |   |  |  |  |   |  |                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, NOTIFY MEDICAL EXAMINER)  |                                  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                         |  |  |   |  |                  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m.<br>p.m. 19   |                                  |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>            |  | 20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) |   | 20f. (City or town) (County) (State)               |                  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 15, 1967</b> , to <b>April 6, 1967</b> , that (H) (we) last saw the deceased alive on <b>April 6, 1967</b> , and that death occurred at <b>M</b> , from causes and on the date stated above.   |                                  |   |  |  |  |   |  |                  |
| 22a. SIGNATURE<br><b>Silvino B. Muneses</b>  |                                  |   | 22b. DATE SIGNED<br><b>April 6, 1967</b>   |  |  |   |  |                  |
| 22c. PHYSICIAN'S<br>NAME (Type)<br><b>Silvino B. Muneses</b>   |                                  |   | 22d. ADDRESS<br><b>5004 Ritchie Hwy. Balt-Md.</b>  |  |  |   |  |                  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>April 10, 1967</b>  |  | 23c. NAME OF CEMETERY OR CREMATORIUM<br><b>Baltimore Nat. Cem.</b> |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b> |  |                  |
| 24. FUNERAL DIRECTOR<br><b>George J. Gonce 4001 Ritchie Hwy. (21225)</b>   |                                  |   | ADDRESS  |  | 25a. REC'D BY REGISTRAR<br><b>APR 11 1967</b>                          |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b> |                  |
| VR A15 (4)<br>20 M 1/66  |                                  |   |  |  |  |   |  |                  |

Q6236

Q6236

Winnipeg

Montreal

Toronto

Montreal

Vancouver

Montreal, Quebec

Montreal, Quebec

Montreal

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Montreal, Quebec, Canada

Montreal, Quebec, Canada

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the attending physician, then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04570

## CERTIFICATE OF DEATH

04571

|   |                              |  |   |
|---|------------------------------|--|---|
| 1. PLACE OF DEATH<br>o. COUNTY<br><b>Anne Arundel</b> MARYLAND  |                              | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE<br><b>Maryland</b> b. COUNTY<br><b>Anne Arundel</b>          |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Glen Burnie</b>  |                              | c. LENGTH OF STAY IN lb  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>North Arundel Hospital</b>   |                              | d. STREET ADDRESS<br><b>105 Phelps Ave.</b>  |   |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                              |  |   |
| 3. NAME OF DECEASED First <b>Minnie</b> Middle <b>Wilhelmina</b> Last <b>Haas</b>   |                              | 4. DATE OF DEATH Month <b>April</b> Day <b>7</b> Year <b>1967</b>  |   |
| S. SEX <b>F</b>   | 6. COLOR OR RACE <b>Cau.</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    | B. DATE OF BIRTH <b>April 3, 1873</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housework (ret.)</b>  |                              | 9. AGE (In years lost birthday) <b>94</b> yrs.<br>11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>                                       |   |
| 13. FATHER'S NAME<br><b>(unknown) ALTVATER</b>  |                              | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>   |                              | 16. SOCIAL SECURITY NO. <b>unknown</b>   |   |
| 17. INFORMANT <b>Mrs. John Wyant, Jr. (daughter)</b>  |                              | Address <b>same as #2</b>  |   |
| IB. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (o) <b>493X</b> DUE TO <b>Pneumonia</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>   |                              |  |   |
| Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause (b) DUE TO <b>Heart heart failure</b>  |                              |  |   |
| (c) <b>lost.</b>  |                              |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)  |                              | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. <b>p.m.</b> 19  |                              | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) <b>Baltimore</b> (County) <b>Maryland</b> (State) <b>MD</b> |
| 21. I certify that (I) (this hospital) attended the deceased from <b>April 7, 1967</b> , to <b>April 7, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 7, 1967</b> , and that death occurred at <b>5 PM</b> , from causes and on the date stated above. |                              | 22b. DATE SIGNED <b>April 7, 1967</b>  |   |
| 22a. SIGNATURE <b>Robert Dabkins</b>  |                              | M.D. ATTENDING MED. DIRECTOR STAFF PHYS. <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                 | 22b. DATE SIGNED <b>April 7, 1967</b>   |
| 22c. PHYSICIAN'S NAME (Type) <b>ROBERT DABKINS, M.D.</b>  |                              | 22d. ADDRESS <b>400 Craig Hwy New Glen Burnie, Md.</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                              | 23b. DATE THEREOF <b>April 10, 1967</b>  | 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Mt. Carmel Cemetery</b> 250 FT BY REGISTRAR <b>Baltimore, Maryland</b>                                    |
| 24. FUNERAL DIRECTOR <b>R. V. Smythe</b>  |                              | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |   |
| VR A15 (4)<br>20 M 1/66   |                              | DATE <b>APR 11 1967</b>  |   |

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69210

anti-Louis

protection - self defense - defense of the state

(protection) - self defense - defense of the state

State must be able to defend itself - self defense - defense of the state

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04571

## CERTIFICATE OF DEATH

04572

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)<br>a. STATE<br><b>Maryland</b> |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Glen Burnie</b>  |  | b. COUNTY<br><b>Anne Arundel</b>   |   |
| c. LENGTH OF STAY IN 1b<br><b>1 year</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Pasa dena</b>                 |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not, in-hospital, give street address)<br><b>Fla za Manor Inc. 7355 Fur.Br. Rd.</b>  |  | d. STREET ADDRESS<br><b>Route 2 Box 420</b>  |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Lottie</b>   |  | First<br><b>L</b>  | Middle<br><b>Handy</b>  |
| 4. DATE OF DEATH<br><b>4 12 19 67</b>   |  | Month<br><b>4</b>  | Day<br><b>12</b>  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>Negro</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>          |
| 8. DATE OF BIRTH<br><b>10/18/1892</b>   |  | 9. AGE (In years last birthday)<br><b>74 yrs.</b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House wife</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Anne Arundel, Md.</b>   |
| 13. FATHER'S NAME<br><b>Humphrey</b>  |  | 14. MOTHER'S MAIDEN NAME   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give rank or date of service<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.  | 17. INFORMANT<br><b>Patients Chart</b>  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>Coronary Occlusion</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO<br>(c) |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Sev. Hrs.</b>   |   |
| C.V.A. e Hypertensive Cardio-Vascular disease and Cerebral Arteriosclerosis   |  | 2 Days   |   |
| Diabetes Mellitus   |  | Sev. Yrs.  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                               |   |
| 20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)                         |   |
| 20c. TIME OF INJURY<br>Hour a.m.<br>p.m.<br><b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>            | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>(None)</b>   |
| 20f. (City or town)<br><b>(None)</b>  |  | (County) (State)   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>March 22, 1966</b> to <b>April 12, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 11, 1967</b> , and that death occurred at <b>Glen Burnie</b> from the causes and on the date stated above.               |  | 22b. DATE SIGNED<br><b>April 12, 1967</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Richard H. Hunt</b>  |  | M.D.   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/><br><b>Richard H. Hunt</b> |
| 22d. ADDRESS<br><b>10 Cherry Lane, Glen Burnie, Md.</b>   |  |  |   |
| 23e. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>4-20-67</b>  | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>Mt. Zion Cemetery</b>  |
| 23d. LOCATION (City, town or county)<br><b>Magadeth Maryland</b>  |  | 25e. REC'D BY REGISTRAR<br><b>Charles R. Law</b>   |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Charles R. Law, 802 Madison Ave.</b>   |  | ADDRESS  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles R. Law</b>   |

5240

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04572

## CERTIFICATE OF DEATH

04573

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |                    |  |   |  |   |
|---|--------------------|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Anne Arundel MARYLAND   |                    | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE Maryland b. COUNTY Anne Arundel                              |   |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie 3 Days   |                    | c. LENGTH OF STAY IN lb<br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton  |   |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>North Arundel Glen Burnie Md.   |                    | d. STREET ADDRESS<br>1406 Annapolis Rd.  |   |  |   |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                    |  |   |  |   |
| 3. NAME OF DECEASED<br>(Type or print)  | First James        | Middle E.  | Last Harvey Sr.   |  |   |
| 4. DATE OF DEATH<br>4 22 1967   | Month              | Day  | Year  |  |   |
| S. SEX M  | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIOOWEO <input type="checkbox"/> DIVORCEO <input type="checkbox"/>    | 8. DATE OF BIRTH<br>5/17/01                                     | 9. AGE (In years last birthday) 65 yrs.  | IF UNDER 1 YEAR<br>Months 0oys Hours Min.     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Retired R.R. Engineer  |                    | 10b. KIND OF BUSINESS OR INDUSTRY<br>Penn. R.R.  | 11. BIRTHPLACE (County & State, or foreign country)<br>Maryland |  | 12. CITIZEN OF WHAT COUNTRY?<br>United States |
| 13. FATHER'S NAME<br>William Harvey   |                    | 14. MOTHER'S MAIDEN NAME<br>Jennie Harvey  |   | Address  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) No   |                    | 16. SOCIAL SECURITY NO.<br>717-07-8934   |   | 17. INFORMANT<br>Mrs. Mildred S. Harvey (wife) Same as #2                          |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>331X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a),<br>stating the underlying cause (b) DUE TO<br>last. (c) |                    | Cerebral vascular accident   |   | INTERVAL BETWEEN ONSET AND DEATH<br>4 days   |   |
| Generalized arteriosclerosis  |                    | Generalized arteriosclerosis   |   | years  |   |
| Gouty hypertension  |                    | Gouty hypertension   |   | years  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)<br>Diabetes mellitus   |                    |  |   |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)   |   |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. 19   |                    | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>of work <input type="checkbox"/> at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)             |   |
| 20f. (City or town) (County) (State)  |                    |  |   |  |   |
| 21. I certify that (I) (this hospital) attended the deceased from 4/18, 1967 to 4/22, 1967, that (I) (we) last saw the deceased alive on 4/22, 1967, and that death occurred at 4:28 AM, from causes and on the date stated above.                                |                    |  |   |  |   |
| 22a. SIGNATURE<br>Max C. Frank Jr.  |                    | M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                                      |   | 22b. DATE SIGNED<br>4/22/67  |   |
| 22c. PHYSICIAN'S NAME (Type) MAX C. FRANK Jr.   |                    | 22d. ADDRESS<br>425 5th Street - Glen Burnie, Md.  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |                    | 23b. DATE THEREOF<br>April 25, 1967  |   | 23c. NAME OF CEMETERY OR CREMATORIUM<br>Glen Haven Memorial Park, Glen Burnie, Md. |   |
| 23d. LOCATION (City or Town) (County) (State)   |                    |  |   |  |   |
| 24. FUNERAL DIRECTOR<br>Richard V. Singleton  |                    | ADDRESS<br>Glen Burnie, Md.  |   | 25a. RECD BY REGISTRAR<br>OATE APR 24 1967   |   |
|   |                    |  |   | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge  |   |

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

2  
1  
04573

CERTIFICATE OF DEATH

04574

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages and 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |   |  |   |
|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><i>Anne Arundel</i> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <i>MARYLAND</i> b. COUNTY <i>Anne Arundel</i>  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Annapolis</i>   |   | c. LENGTH OF STAY IN 1b<br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>ROUTE 1 EDGEWATER</i>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><i>A.A. GENERAL HOSPITAL</i>   |   | d. STREET ADDRESS  |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><i>THOMAS</i>  |   | First  | Middle  |
| 4. DATE OF DEATH<br><i>HICKLEY APRIL 2 1967</i>  | Month   | Day  | Year  |
| 5. SEX<br><i>MALE</i>  | 6. COLOR OR RACE<br><i>WHITE</i>                    | 7. MARRIED<br>WIDOWED <input checked="" type="checkbox"/>  | NEVER MARRIED <input type="checkbox"/><br>DIVORCED <input type="checkbox"/>                                   |
| 8. AGE (In years<br>at last birthday)<br><i>86 yrs.</i>  | 9. IF UNDER 1 YEAR<br>Months <i>0</i> Dofs <i>0</i> | 10. IF UNDER 24 HRS.<br>Hours <i>0</i> Min. <i>0</i>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br><i>ELECTRICAL CONTRACTOR</i>   |   | 10b. KIND OF BUSINESS OR<br>INDUSTRY <i>CONSTRUCTION</i>   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><i>INDIANA</i>  |   | 12. CITIZEN OF WHAT<br>COUNTRY <i>U.S.A.</i>   |   |
| 13. FATHER'S NAME<br><i>ARTHUR HICKLEY</i>   |   | 14. MOTHER'S MAIDEN NAME<br><i>MARY BREWER</i>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <i>No</i>   |   | 16. SOCIAL SECURITY NO.<br><i>THOMAS J. HICKLEY</i> Address<br><i>10605 AMHURST AVE. SILVER SPRINGS MD.</i>  |   |
| 17. INFORMANT<br><i>THOMAS J. HICKLEY</i>  |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>CEREBRAL THROMBOSIS</i><br>DUE TO <i>332X</i> INTERVAL BETWEEN<br>ONSET AND DEATH <i>12 hours</i><br>Conditions, if any, which gave rise to immediate cause (a),<br>stating the underlying cause lost. (b) _____ (c) _____ |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)<br><i>ARTEROSCLEROTIC HEART DIS; CARCINOMA PROSTATE</i>   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m.<br>p.m. <i>19</i>  |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)<br>20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <i>12/15 1965</i> to <i>4/2 1967</i> that (I) (we) last saw the deceased alive on <i>4/3 1967</i> , and that death occurred at <i>8307</i> M., fram causes and on the date stated above. |   | 22b. DATE SIGNED<br><i>4/3/67</i>  |   |
| 22c. PHYSICIAN'S NAME (Type) <i>EDWARD S. BECK</i>   |   | 22d. ADDRESS<br><i>73 FRANKLIN ST ANNAPOLIS MD</i>   |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><i>BURIAL</i>  |   | 23b. DATE THEREOF<br><i>APRIL 5, 1967</i>  | 23c. NAME OF CEMETERY OR CREMATORIAL<br><i>MONMOUTH MEM. PARK</i>   |
| 24. FUNERAL DIRECTOR<br><i>JOHN M. TAYLOR &amp; SONS ANNAPOLIS MD.</i>   |   | 23d. LOCATION (City or Town) (County) (State)<br><i>ASBURY PARK N.J.</i>   | 25a. REC'D. BY REGISTRAR<br>DATE <i>APR 4 1967</i>  |
|  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |   |

67330

OFFICE OF THE  
COMPTROLLER OF CURRENCY

REGULATIONS GOVERNING NATIONAL BANKS

1933  
1933

W. T. GALLAGHER  
Comptroller

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #8 Film #G387 1/11/67 pc

04574

## CERTIFICATE OF DEATH

04575

|  |                                  |  |  |  |  |  |                      |                     |
|--|----------------------------------|--|--|--|--|--|----------------------|---------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b> MARYLAND   |                                  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> |  |  |                      |                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Glen Burnie</b>   |                                  | c. LENGTH OF STAY IN lb<br><b>3 days</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Glen Burnie</b>               |  | b. COUNTY<br><b>Anne Arundel</b>   |                      |                     |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>North Arundel</b>   |                                  |  |  | d. STREET ADDRESS<br><b>401 Crain Highway N.E.</b>   |  |  |                      |                     |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |  |  |  |  |  |                      |                     |
| 3. NAME OF DECEASED (Type or print)  |                                  | First<br><b>Alice</b>  | Middle<br><b>G.</b>                    | Last<br><b>Hilbert</b>   | 4. DATE OF DEATH<br><b>April 10 1967</b> | Month<br><b>April</b>  | Doy<br><b>10</b>     | Year<br><b>1967</b> |
| S. SEX<br><b>female</b>  | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED<br><input checked="" type="checkbox"/> NEVER MARRIED<br><input type="checkbox"/> WIDOWED<br><input type="checkbox"/> DIVORCED                       | 8. DATE OF BIRTH<br><b>12-20-11 09</b> | 9. AGE (In years lost birthday)<br><b>57 yrs.</b>  | IF UNDER 1 YEAR<br><b>Months</b>         | IF UNDER 24 HRS.<br><b>Days</b>  | Hours<br><b>02.1</b> | Min.                |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housework</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Laurel, Md.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                            |                      |                     |
| 13. FATHER'S NAME<br><b>(unknown) Schriber</b>   |                                  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Laura E. (unknown)</b>  |  |  |                      |                     |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>unknown</b>  |  | 17. INFORMANT<br><b>Mr. Lloyd F. Hilbert (Huband)</b>  |  | Address<br><b>Same As #2</b>   |                      |                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>4201</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br><b>(b)</b> DUE TO<br><b>(c)</b> DUE TO |                                  |  |  |  |  |  |                      |                     |
| INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b>  |                                  |  |  |  |  |  |                      |                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                                  |  |  |  |  |  |                      |                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |  |                      |                     |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m.<br>p.m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                     |                      |                     |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Oct 16, 1966</b> , to <b>April 10, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 10, 1967</b> , and that death occurred at <b>11:45 AM</b> , from causes and on the date stated above.                     |                                  |  |  |  |  |  |                      |                     |
| 22a. SIGNATURE<br><b>Robert Jabolin</b>  |                                  | M.D. ATTENDING PHYS.   |  | MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                               |  | 22b. DATE SIGNED<br><b>4/10/67</b>                                       |                      |                     |
| 22c. PHYSICIAN'S NAME (Type)<br><b>ROBERT JABOLIN, M.D.</b>  |                                  | 22d. ADDRESS<br><b>400 Crain Hwy N.W. Glen Burnie, Md.</b>   |  |  |  |  |                      |                     |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>April 14, 1967</b>   |  | 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS<br><b>Glen Haven Mem. Pk.</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Glen Burnie, Md.</b> |                      |                     |
| 24. FUNERAL DIRECTOR<br><b>R.V. Singleton</b>  |                                  | ADDRESS<br><b>Singletor Funeral Home</b>   |  | 25a. REC'D BY REGISTRAR<br><b>Glen Burnie, Md.</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                       |                      |                     |
|  |                                  |  |  | DATE<br><b>APR 12 1967</b>   |  |  |                      |                     |

STCDO

86-10-70 DIFFERENT

STCDO

3 mm  
adult (juvenile)  
adult (juvenile)

adult (juvenile) + adult (juvenile) + adult (juvenile) + adult (juvenile)

adult (juvenile) + adult (juvenile) + adult (juvenile)

24 or 25



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04575

**CERTIFICATE OF DEATH**

04576

|   |                                  |  |  |   |   |
|---|----------------------------------|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><i>Anne Arundel</i><br>MARYLAND   |                                  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><i>Maryland</i><br>b. COUNTY<br><i>Anne Arundel</i> |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Glen Burnie</i>  |                                  |  | c. LENGTH OF STAY IN Tb  |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><i>North Arundel Hospital</i>   |                                  |  | d. STREET ADDRESS<br><i>Glen Burnie</i>  |   |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |  |  |   |   |
| 3. NAME OF DECEASED<br>(Type or print)  |                                  | First<br><i>Laura</i>  | Middle   | Lost<br><i>Hillary</i>                                  | 4. DATE OF DEATH<br>Month<br><i>APRIL</i> |
| S. SEX<br><i>Female</i>   | 6. COLOR OR RACE<br><i>White</i> | 7. MARRIED<br><input checked="" type="checkbox"/> NEVER MARRIED<br><input type="checkbox"/> WIDOWED<br><input type="checkbox"/> DIVORCED | B. DATE OF BIRTH<br><i>May 5, 1892</i>   | 9. AGE (In years<br>last birthday)<br><i>74 yrs.</i>    | IF UNDER 1 YEAR<br>Months<br><i>1</i>     |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>Own Home</i>   | 11. BIRTHPLACE (County & State, or foreign country)<br><i>Annapolis, Md.</i>   | 12. CITIZEN OF WHAT COUNTRY?<br><i>A.S.A.</i>           | IF UNDER 24 HRS.<br>Hours<br><i>0</i>     |
| 13. FATHER'S NAME<br><i>William Sheppard</i>  |                                  | 14. MOTHER'S MATEW NAME<br><i>Emma Stewart</i>   |  |   | Address<br><i>Same As #2</i>              |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><i>No</i>   |                                  | 16. SOCIAL SECURITY NO.<br><i>None</i>   | 17. INFORMANT<br><i>Mr. Frederick S. Hillary (husband)</i>   | INTERVAL BETWEEN ONSET AND DEATH<br><i>Today</i>        |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><i>4201</i><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)<br>DUE TO<br>last<br>(c) |                                  |  |  |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)  |                                  |  |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)   |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m.<br>p.m.<br><i>19</i>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>                                | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town)<br><i>Glen Burnie</i>               | (County) (State)<br><i>Anne Arundel</i>   |
| 21. I certify that (I) (this hospital) attended the deceased from <i>April 1, 1967</i> , to <i>April 1, 1967</i> , that (I) (we) last saw the deceased alive on <i>April 1, 1967</i> , and that death occurred at <i>6:30 PM</i> , from causes and on the date stated above.      |                                  |  |  |   |   |
| 22a. SIGNATURE<br><i>Robert Dabollins</i>   |                                  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>   | MED. DIRECTOR <input type="checkbox"/>   | STAFF PHYS. <input type="checkbox"/>                    | 22b. DATE SIGNED<br><i>April 1, 1967</i>  |
| 22c. PHYSICIAN'S NAME (Type)<br><i>ROBERT DABOLINS, MD</i>  |                                  | 22d. ADDRESS<br><i>North Arundel Hospital, Glen Burnie, Md.</i>  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |                                  | 23b. DATE THEREOF<br><i>Apr. 14, 1967</i>  | 23c. NAME OF CEMETERY OR CREMATORIAL<br><i>Glen Haven Memorial</i>   | 23d. LOCATION (City or Town)<br><i>Glen Burnie, Md.</i> | (County) (State)<br><i>Anne Arundel</i>   |
| 24. FUNERAL DIRECTOR<br><i>P. J. Singleton</i>  |                                  | ADDRESS<br><i>Singleton Funeral Home<br/>Glen Burnie, Md.</i>  | 25a. REC'D BY REGISTRAR<br><i>APR 4</i>  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>      |   |

85240

85240

Smooth wavy

Smooth wavy

Latidens labrum dark

♂ - 481, 24M

Smooth wavy

A.C. 11

brown elegant

smooth

smooth

transverse wavy

bristly wavy

2mm (dark) pale 2.2 times W. wavy wavy on

Smooth wavy short smooth wavy smooth wavy

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04576

## CERTIFICATE OF DEATH

04577

|  |   |  |  |  |
|--|---|--|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY<br><b>Anne Arundel</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE<br><b>Maryland</b>   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b>   | c. LENGTH OF STAY IN lb<br><b>5 months</b>  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>   | d. STREET ADDRESS<br><b>2420 E. North Ave</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Crownsville State Hospital</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |
| 3. NAME OF DECEASED<br>(Type or print) #33845  | First<br><b>Joseph</b>  | Middle<br><b>B.</b>  | Last<br><b>Holland</b>   |  |
| 4. DATE OF DEATH<br><b>4 18 1967</b>   | Month<br>Year   | Doy<br>Year  | Month<br>Year  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED<br>WIDOWED <input checked="" type="checkbox"/><br>DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>10/25/81</b>  |  |
| 9. AGE (In years<br>last birthday)<br><b>85</b> yrs.   | 10. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br><b>Machinist</b> | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Connecticut</b>  | 12. CITIZEN OF WHAT<br>COUNTRY? <b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>John Holland</b>   | 14. MOTHER'S MAIDEN NAME<br><b>? Brown</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b>   | 16. SOCIAL SECURITY NO.<br><b>705-05-0969</b>   | 17. INFORMANT<br><b>Hospital Records</b>   | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (o)<br><b>Arteriosclerotic Cardio-Vascular Disease</b>  |   |  | INTERVAL BETWEEN<br>ONSET AND DEATH  |  |
| DUE TO<br>Conditions, if any, which gave<br>rise to immediate cause (o),<br>stating the underlying cause<br>lost.<br>(b) <b>Generalized Arteriosclerosis</b>   |   |  |  |  |
| DUE TO<br>(c)  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)<br><b>Infection of Left Leg and Inanition</b>   |   |  | 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>-----  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m.<br>----- P.M. 19   |   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm,<br>factory, street, office bldg., etc.)<br>-----                   | 20f. (City or town) (County) (State)<br>-----      |
| 21. I certify that (I) (this hospital) attended the deceased from <b>11/16/1966</b> , to <b>4/18/1967</b> , that (I) (we) last<br>saw the deceased alive on <b>4/18/1967</b> , and that death occurred at <b>8:30</b> M, from causes and on the date stated above.<br>A. |   |  |  |  |
| 22a. SIGNATURE<br><i>L. Benedict</i>   |   | M.D. ATTENDING PHYS. <input type="checkbox"/><br>MED. DIRECTOR <input checked="" type="checkbox"/><br>STAFF PHYS. <input type="checkbox"/>                     | 22b. DATE SIGNED<br><b>4/18/67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>L. Benedict, M.D.</b>   |   | 22d. ADDRESS<br><b>Crownsville State Hospital, Maryland</b>  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>4/21/67</b>   | 23c. NAME OF CEMETERY OR CREMATORIUM<br><b>Baltimore Cemetery</b>  | 23d. LOCATION (City or Town)<br><b>Baltimore, Md.</b>  | (County) (State)                                   |
| 24. FUNERAL DIRECTOR<br><b>Ullrich Funeral Home 4210 Belair Road.</b>  |   |  | ADDRESS  | 25a. REC'D BY REGISTRAR<br><b>APR 24 1967</b>      |
|  |   |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i> |

100

3380

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                              |  |   |  |  |  |  |  |  |  |   |  |  |  |  |  |
|---|--|------------------------------|--|---|--|--|--|--|--|--|--|---|--|--|--|--|--|
| CERTIFICATE OF DEATH  |  |                              |  |   |  | 04578  |  |  |  |  |  |   |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b><br><b>MARYLAND</b>  |  |                              |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Anne Arundel</b>   |  |  |  |  |  |   |  |  |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>  |  |                              |  |   |  | c. LENGTH OF STAY IN 1b<br><b>1b</b>   |  |  |  |  |  |   |  |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>U.S. Naval Hospital, Annapolis, Md.</b>  |  |                              |  |   |  | e. STREET ADDRESS<br><b>1200 Forrest Drive, Annapolis, Md.</b>   |  |  |  |  |  |   |  |  |  |  |  |
| f. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                              |  |   |  |  |  |  |  |  |  |   |  |  |  |  |  |
| 3. NAME OF DECEASED First <b>Charles</b> Middle <b>Franklin</b> Last <b>HORTON</b>  |  |                              |  |   |  | 4. DATE OF DEATH Month <b>April</b> Day <b>18</b> Year <b>1967</b>   |  |  |  |  |  |   |  |  |  |  |  |
| 5. SEX <b>M</b>   |  | 6. COLOR OR RACE <b>Cauc</b> |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>5 July 1904</b>  |  | 9. AGE (In years last birthday) <b>62 yrs.</b> |  | 10. IF UNDER 1 YEAR Months <b>6</b> Days <b>2</b> Hours <b>0</b> Min. <b>0</b> |  |   |  |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>USN RET</b>   |  |                              |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>USN RET</b>  |  |  |  |  |  |   |  |  |  |  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>ALTOONA PENN</b>  |  |                              |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |  |  |  |   |  |  |  |  |  |
| 13. FATHER'S NAME<br><b>Carl F. Horton</b>  |  |                              |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>BESSIE L. FILLER</b>  |  |  |  |  |  |   |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b><br>(If yes give war or dates of service)<br><b>Unknown</b>   |  |                              |  |   |  | 16. SOCIAL SECURITY NO. <b>1200 Forrest Drive,</b><br>17. INFORMANT <b>Mrs. Agnes Horton (W)</b><br>Address <b>Annapolis, Md.</b>  |  |  |  |  |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b><br>DUE TO<br>Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____<br>(c) _____<br>331X |  |                              |  |   |  |  |  |  |  |  |  |   |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>2 hrs .40 min.  |  |                              |  |   |  |  |  |  |  |  |  |   |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                              |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)<br>20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br>p.m. <b>19</b> At work <input type="checkbox"/> |  |  |  |  |  | 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State) |  |  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>2350 4-17, 1967</b> to <b>0220 4-18, 1967</b> , that (I) (we) last saw the deceased alive on <b>18 April 1967</b> , and that death occurred at <b>0220M</b> , from the causes and on the date stated above.                            |  |                              |  |   |  |  |  |  |  |  |  | 22b. DATE SIGNED <b>18 April 1967</b>   |  |  |  |  |  |
| 22a. SIGNATURE <b>J. Patlovich, LCDR MC USN</b>   |  |                              |  |   |  | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |  |  |  |  |   |  |  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>J. Patlovich, LCDR MC USN</b>   |  |                              |  |   |  | 22d. ADDRESS <b>U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.</b>  |  |  |  |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |  |                              |  |   |  | 23b. DATE THEREOF <b>4-21-67</b>   |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l. Cemetery</b>   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>JOHN M. TAYLOR AND SONS FUNERAL HOME</b>   |  |                              |  |   |  | 25a. REC'D BY REGISTRAR <b>APR 24 1967</b>   |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE <b>Charles J. Taylor</b>   |  |  |  |  |  |
| DUKE OF GLOUCESTER ST., ANNAPOLIS, MD.  |  |                              |  |   |  |  |  |  |  |  |  |   |  |  |  |  |  |

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## WILHELM HOPPE

2025 RELEASE UNDER E.O. 14176

NEW YORK, NOVEMBER 1.

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EMERITUS PROFESSOR OF POLYGRAPHY AND  
DIRECTOR OF THE POLYGRAPHIC INSTITUTE

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

04578

## **CERTIFICATE OF DEATH**

04579

|   |                         |   |   |  |   |
|---|-------------------------|---|---|--|---|
| 1. PLACE OF DEATH<br>o. COUNTY ANNE ARUNDEL MARYLAND  |                         |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE MARYLAND b. COUNTY ANNE ARUNDEL |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>FT GEO G MEADE  |                         | c. LENGTH OF STAY IN lb<br>7 Hours  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>FORT GEORGE G. MEADE |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>KIMBROUGH ARMY HOSPITAL   |                         |   | d. STREET ADDRESS<br>4548 ENGLISH AVENUE  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) FIRST MIDDLE LAST<br>KATHRYN SETTLE HUNDLEY   |                         | 4. DATE OF DEATH<br>APRIL 17 1967   |   | Month Day Year   |   |
| S. SEX<br>FEMALE  | 6. COLOR OR RACE<br>CAU | 7. MARRIED<br>WIDOWED   | NEVER MARRIED<br>DIVORCED   | 8. DATE OF BIRTH<br>JUNE 10, 1918  | 9. AGE (In years<br>lost birthday)<br>48 yrs.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife  |                         | 10b. KIND OF BUSINESS OR INDUSTRY<br>None   |   | 11. BIRTHPLACE (County & State, or foreign country)<br>ROSEDALE, VIRGINIA                                |   |
| 13. FATHER'S NAME<br>FRED B. SETTLE   |                         |   | 14. MOTHER'S MAIDEN NAME<br>SUSIE CRABTREE  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> NO<br><input type="checkbox"/> N/A   |                         | 16. SOCIAL SECURITY NO.<br>553-44-9526  |   | 17. INFORMANT (husband) Address<br>Col. M. Hundley, Jr. 4548 English Ave, FGGM, Md                       |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Subarachnoid Hemorrhage</b> INTERVAL BETWEEN ONSET AND DEATH  |                         |   |   |  |   |
| 330X<br>Conditions, if any, which gave rise to immediate cause (a).<br>stating the underlying cause (b) _____<br>lost. (c) _____  |                         |   |   |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)   |                         |   |   |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                         | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. 19 p.m.   |                         | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>                               | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town)  | (County) (State)  |
| 21. I certify that (1) (this hospital) attended the deceased from 16 Apr, 1967, to 17 Apr, 1967 that (1) (we) last saw the deceased alive on 17 April 1967 and that death occurred at 5:03aM, from causes and on the date stated above. |                         |   |   |  |   |
| 22a. SIGNATURE<br><i>Stuart Brager</i>  |                         | M.D. ATTENDING PHYS. <input type="checkbox"/><br>MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | 22b. DATE SIGNED<br>17 April 1967   |  |   |
| 22c. PHYSICIAN'S NAME (Type)<br>STUART H. BRAGER, CPT, MC   |                         | 22d. ADDRESS<br>KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>CREMATION 18 April 1967  |                         | 23b. DATE THEREOF<br>18 April 1967  |   | 23c. NAME OF CEMETERY OR CREMATORIUM<br>LEE CEMETERY OR CREMATORIUM                                      |   |
| 24. FUNERAL DIRECTOR<br>Rivaldo's Funeral Home  |                         | ADDRESS<br>WASH DC  |   | 25a. LOCATION (City or Town)<br>Washington DC.   | (County) (State)  |
|   |                         |   |   | 25b. RECEIVED BY REGISTRAR<br>APR 18 1967  | RECEIVED BY JUDGE<br><i>Charles Judge</i>   |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**0 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal in any event, within 72 hours after death.



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

|   |                         |  |  |   |  |                                  |        |           |
|---|-------------------------|--|--|---|--|----------------------------------|--------|-----------|
| 1. PLACE OF DEATH<br>o. COUNTY  |                         | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE  |  |   |  |                                  |        |           |
| Anne Arundel County, Maryland   |                         | Maryland   |  |   |  |                                  |        |           |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  | c. LENGTH OF STAY IN lb | b. COUNTY  |  |   |  |                                  |        |           |
| Crownsville   | 27 Days                 | Baltimore  |  |   |  |                                  |        |           |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |                         | d. STREET ADDRESS  |  |   |  |                                  |        |           |
| Crownsville State Hospital  |                         | 152 1/2 Decker Street  |  |   |  |                                  |        |           |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  |                         | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |                                  |        |           |
| 3. NAME OF DECEASED (Type or print)   |                         | First Edna   | Middle   | Lost Hunger   | 4. DATE OF DEATH                         | Month 4                          | Day 15 | Year 1967 |
| 5. SEX F  | 6. COLOR OR RACE C      | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | B. DATE OF BIRTH 1-27-03   | 9. AGE (In years lost birthday) 64 yrs.   | IF UNDER 1 YEAR Months                   | IF UNDER 24 HRS. Days Hours Min. |        |           |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                         | 10b. KIND OF BUSINESS OR INDUSTRY  | 11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.     |   | 12. CITIZEN OF WHAT COUNTRY? USA         |                                  |        |           |
| Housewife   |                         | —  |  |   |  |                                  |        |           |
| 13. FATHER'S NAME Zora B. Mason   |                         | 14. MOTHER'S MAIDEN NAME Annie Mason   |  | Address   |  |                                  |        |           |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No  |                         | 16. SOCIAL SECURITY NO. Yes Unknown  | 17. INFORMANT Medical Records  | INTERVAL BETWEEN ONSET AND DEATH  |  |                                  |        |           |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Heart Failure<br>4500<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |                         | DUE TO<br>(b) Marked Dehydration + Electrolyte Imbalance<br>DUE TO<br>(c) Arteriosclerosis, Generalized  |  |   |  |                                  |        |           |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                         |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                  |        |           |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                         | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |                                  |        |           |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m.<br>p.m. 19  |                         | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town)   | (County)                                 | (State)                          |        |           |
| 21. I certify that (I) (this hospital) attended the deceased from 3-19, 1967, to 4-15, 1967, that (I) (we) last saw the deceased alive on 4-15 1967, and that death occurred at 9:00 P.M. from causes and on the date stated above. |                         | 22b. DATE SIGNED 4-15-67   |  |   |  |                                  |        |           |
| 22a. SIGNATURE Alvin M. Brown, M.D.   |                         | M.D. ATTENDING PHYS. <input type="checkbox"/>  | MED. DIRECTOR <input type="checkbox"/>                                 | STAFF PHYS. <input checked="" type="checkbox"/>                                     |  |                                  |        |           |
| 22c. PHYSICIAN'S NAME (Type) Alvin M. Brown, M.D.   |                         | 22d. ADDRESS 2231 Montebello Terrace, Baltimore  |  |   |  |                                  |        |           |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial  |                         | 23b. DATE THEREOF 4/19/67  | 23c. NAME OF CEMETERY OR CREMATORIUM Sacred Heart of Jesus Cemetery    | 23d. LOCATION (City or Town) Baltimore  | (County) Maryland                        | (State)                          |        |           |
| 24. FUNERAL DIRECTOR John A. Moran, Inc.  |                         | ADDRESS 3000 E. Baltimore St.  | 25a. REC'D. BY REGISTRAR APR 18 1967                                   |   | 25b. REGISTRAR'S SIGNATURE Charles Judge |                                  |        |           |
| VR A15 (4)<br>20 M 1/66   |                         |  | DATE   |   |  |                                  |        |           |

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                                  |   |   |  |  |  |  |  | CERTIFICATE OF DEATH  |  | 04581 |  |
|---|--|----------------------------------|---|---|--|--|--|--|--|---|--|-------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b><br>c. LENGTH OF STAY IN 1b<br><b>MARYLAND</b><br><b>hrs.</b>  |  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Anne Arundel</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b> |  |  |  |  |   |  |       |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>North Arundel General</b>  |  |                                  |   |   | e. STREET ADDRESS<br><b>510 Sylvie Drive</b>   |  |  |  |  | f. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |       |  |
| 3. NAME OF<br>DECEASED<br>(Type or print)   |  | First<br><b>GEORGE</b>           | Middle<br><b>EDWARD</b>   | Last<br><b>IMHOFF</b>                   | 4. DATE<br>OF<br>DEATH   | Month<br><b>April</b>  | Day<br><b>17,</b>                        | Year<br><b>19 67</b>   |  |   |  |       |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Dec. 1, 1884</b> | 9. AGE (In years<br>last birthday)<br><b>82</b><br>yrs.  | 10. IF UNDER 1 YEAR<br>Months<br><b>82</b>                                   | 11. IF UNDER 24 HRS.<br>Days<br><b>0</b> | 12. IF UNDER 24 MIN.<br>Hours<br><b>0</b>  |  |   |  |       |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Officer Manager</b>   |  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Dept. Store</b>   |   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Md.</b> |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b> |   |  |       |  |
| 13. FATHER'S NAME<br><b>Francis L. Imhoff</b>   |  |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Ottilim Schnapp</b>   |  |  |  |  |   |  |       |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>   |  |                                  | 16. SOCIAL SECURITY NO.<br><b>218-07-0415</b>   |   |  | 17. INFORMANT<br><b>Mrs. Bridget V. Imhoff</b> Same                          |  |  | Address                                      |   |  |       |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>443 X</b><br>Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Congestive Heart failure</b><br>DUE TO<br>(b) <b>Hypertension C. V disease</b><br>DUE TO<br>(c) <b>Rheumatic Heart disease</b> |  |                                  |   |   |  |  |  |  |  | INTERVAL BETWEEN<br>ONSET AND DEATH<br><b>2 weeks</b>   |  |       |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)<br><b>Emphysema</b>  |  |                                  |   |   |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |       |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                  |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)<br><b>Injury</b>  |  |  |  |  |   |  |       |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m.<br>p.m.   |  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town)<br><b>Baltimore</b>  |  | (County)<br><b>Md.</b>                       |   |  |       |  |
| (State)<br><b>19</b>  |  |                                  |   |   |  |  |  |  |  |   |  |       |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Apr 15, 1967</b> , to <b>Apr 15, 1967</b> , that (I) (we) last saw the deceased alive on <b>Apr 15, 1967</b> , and that death occurred at <b>8 a.m.</b> M, from the causes and on the date stated above.   |  |                                  |   |   |  |  |  |  |  |   |  |       |  |
| 22a. SIGNATURE<br><b>Joseph N Zierler</b>   |  |                                  |   |   |  |  |  |  |  | 22b. DATE SIGNED<br><b>April 18, 1967</b>   |  |       |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Joseph N Zierler</b>   |  |                                  |   |   | 22d. ADDRESS<br><b>2502 Eutaw Place Balto. Md.</b>   |  |  |  |  |   |  |       |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |                                  | 23b. DATE THEREOF<br><b>April 20, 1967</b>  |   | 23c. NAME OF CEMETERY OR CREMATORIUM<br><b>Holy Cross Cem.</b>   |  |  | 23d. LOCATION (City, town or county) (State)<br><b>Ritchie Hwy. A. A. Co., Md.</b> |  |   |  |       |  |
| 24. FUNERAL DIRECTOR<br><b>George J. Gonce 4001 Ritchie Hwy. (21225)</b>  |  |                                  |   |   | ADDRESS  |  |  |  |  | 25a. REC'D BY REGISTRAR<br><b>APR 21 1967</b>   |  |       |  |
|   |  |                                  |   |   |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |       |  |

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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**CERTIFICATE OF DEATH**

04582

|   |                        |  |   |  |   |
|---|------------------------|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY Anne Arundel County MARYLAND   |                        |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE Maryland b. COUNTY Anne Arundel |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Glen Burnie Md.   |                        | c. LENGTH OF STAY IN 16<br>24 hrs.   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Rural Baltimore Md.        |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>North Arundel Hospital  |                        |  | d. STREET ADDRESS<br>625 New Jersey Ave.  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print) First Eleanor Middle V. Ingle  |                        | Lost   |   | 4. DATE OF DEATH<br>April 3 1967   | Month Day Year  |
| S. SEX F  | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br>8-14-92   | 9. AGE (In years last birthday)<br>74 1/2 yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                        | 10b. KIND OF BUSINESS OR INDUSTRY<br>Retired   |   | 11. BIRTHPLACE (County & State, or foreign country)<br>Ill.  |   |
| 13. FATHER'S NAME<br>Unk  |                        |  | 14. MOTHER'S MAIDEN NAME<br>Unk   |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <input checked="" type="checkbox"/>  |                        | 16. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br>Family Address Same   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><br>4200<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause<br>{<br>DUE TO<br>(b)<br>DUE TO<br>(c)<br>DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)<br>Bronchopneumonia<br>ASHD |                        |  | INTERVAL BETWEEN ONSET AND DEATH<br>3 days  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, NOTIFY MEDICAL EXAMINER)   |                        | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m.<br>p.m. 19  |                        | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State) |   |
| 21. I certify that (I) (this hospital) attended the deceased from June 15, 1962, to April 3, 1967, that (I) (we) last saw the deceased alive on April 3, 1967, and that death occurred at 4:45 PM, from causes and on the date stated above.  |                        |  |   |  |   |
| 22a. SIGNATURE<br>Robert Daboll   |                        |  | 22b. DATE SIGNED<br>April 3, 1967   |  |   |
| 22c. PHYSICIAN'S NAME (Type)<br>ROBERT DABOLINS, MD   |                        | 22d. ADDRESS<br>900 Craig Hwy N.W. Glen Burnie Md  |   |  |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial  |                        | 23b. DATE THEREOF<br>4/6/67  |   | 23c. NAME OF CEMETERY OR CREMATORIALy<br>Glen Haven  |   |
| 24. FUNERAL DIRECTOR<br>McCully F H 237 Patapsco Ave  |                        |  | ADDRESS<br>21225  |  | 25a. REC'D BY REGISTRAR<br>APR 5 1967   |
| 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |                        |  |   |  |   |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**HOSPITAL UK ATTENDING PHYSICIAN:** The law requires that Page 4 may be retained by the hospital or attending physician.

**NO FORTAL OR ATTENDING PHYSICIAN:** I now require that no death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

**NO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages Y ~~and~~ H should be filed with the State Dept. of Health prior to burial, cremation, or removal ~~or~~ H any event, within 72 hours after death.

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

04582

**CERTIFICATE OF DEATH**

04583

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

|   |                           |  |   |
|---|---------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b> MARYLAND  |                           | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> b. COUNTY<br><b>Pasco</b> |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis Md</b>   |                           | c. LENGTH OF STAY IN lb<br><b>3 Months</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>ANNAPOLIS NURSING HOME</b>   |                           | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print) <b>Archibald Archie Bold</b>  |                           | First  | Middle  |
| S. SEX <b>Male</b>  | 6. COLOR OR RACE <b>W</b> | 7. MARRIED<br>WIDOWED <input checked="" type="checkbox"/>  | NEVER MARRIED <input type="checkbox"/><br>DIVORCED <input type="checkbox"/> |
| 10b. KIND OF BUSINESS OR INDUSTRY   |                           | 8. DATE OF BIRTH<br><b>3-3-1885</b>  |   |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>CARPENTER</b>  |                           | 9. AGE (In years lost birthday)<br><b>82 yrs</b>   |   |
| 13. FATHER'S NAME<br><b>Archibald Johnson</b>   |                           | 11. BIRTHPLACE (County & State, or foreign country)<br><b>A.A.C.O MD.</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |                           | 14. MOTHER'S MAIDEN NAME<br><b>MARGARET WARFIELD</b>   |   |
|   |                           | Address <b>VANBUREN</b>  |   |
| 16. SOCIAL SECURITY NO. <b>214-18-1838</b>  |                           | 17. INFORMANT <b>ANNAPO利S NURSING - Bay Ridge Rd</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bilateral hemiplegia - QVA</b><br>DUE TO <b>4281</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Severe ASCVD</b><br>DUE TO <b>15 yrs</b><br>(c) |                           | INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Rt-lower lobe pneumonia - Cong. Heart Failure</b>  |                           |  |   |
| 20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>p.m.</b> 19  |                           | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>                                      | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)      |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1-5</b> , 19 <b>67</b> , to <b>4-4</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>4-4</b> , 19 <b>67</b> , and that death occurred at <b>5:00 PM</b> , from causes and on the date stated above.   |                           | 20f. (City or town) <b>Baltimore</b> (County) <b>Maryland</b> (State)  |   |
| 22o. SIGNATURE <b>Peter F. Verkoun</b>  |                           | 22b. DATE SIGNED <b>4/4/1967</b>   |   |
| 22c. PHYSICIAN'S NAME (Type) <b>PETER F. VERKOUN</b>  |                           | 22d. ADDRESS <b>1407 FOREST DRIVE, ANNAPOLIS</b>   |   |
| 23o. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                           | 23b. DATE THEREOF <b>April 7, 1967</b>   |   |
| 24. FUNERAL DIRECTOR <b>Kirkley Funeral Home, Glen Burnie, Md.</b>  |                           | 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Cedar Hill Cemetery</b>  |   |
|   |                           | 23d. LOCATION (City or Town) <b>Baltimore</b> (County) <b>Maryland</b> (State)   |   |
|   |                           | 25a. RECD BY REGISTRAR <b>APR 7 1967</b>   | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>                             |
|   |                           | DATE   |   |

333

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                  |                |  |   |  |                  |  |                            |                           |                            |   |  |  |  |
|---|--|------------------|----------------|--|---|--|------------------|--|----------------------------|---------------------------|----------------------------|---|--|--|--|
| CERTIFICATE OF DEATH  |  |                  |                |  |   |  |                  |  |                            |                           |                            |   |  |  |  |
| 1. PLACE OF DEATH   |  |                  |                | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)                  |   |  |                  |  |                            |                           |                            |   |  |  |  |
| a. COUNTY Anne Arundel MARYLAND   |  |                  |                | a. STATE Maryland b. COUNTY Arundel  |   |  |                  |  |                            |                           |                            |   |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shady Side   |  |                  |                | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shady Side            |   |  |                  |  |                            |                           |                            |   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Olive Street & Thomas Drive  |  |                  |                | d. STREET ADDRESS Olive Street & Olive Drive   |   |  |                  |  |                            |                           |                            |   |  |  |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                  |                |  |   |  |                  |  |                            |                           |                            |   |  |  |  |
| 3. NAME OF DECEASED (Type or print)   |  |                  |                | First HARRY  | Middle E  | Last JONES   | 4. DATE OF DEATH | Month 4  | Day 7                      | Year 1967                 |                            |   |  |  |  |
| 5. SEX Male   |  |                  |                | 6. COLOR OR RACE White   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | WIDOWED <input type="checkbox"/> DIVDRCD <input type="checkbox"/>      | 8. DATE OF BIRTH | 9. AGE (In years last birthday) 50 yrs.                              | 10. IF UNDER 1 YEAR Months | 11. IF UNDER 24 HRS. Oays | 12. IF UNDER 24 HRS. Hours |   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman   |  |                  |                | 10b. KIND OF BUSINESS OR INDUSTRY D.C. Fire Dept   |   |  |                  | 11. BIRTHPLACE (County & State, or foreign country) Washington, D.C. |                            |                           |                            | 12. CITIZEN OF WHAT COUNTRY? U.S.A.                                 |  |  |  |
| 13. FATHER'S NAME Harry Stahl Jones   |  |                  |                | 14. MOTHER'S MAIDEN NAME Bertha Hyde   |   |  |                  |  |                            |                           |                            |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No  |  |                  |                | 16. SOCIAL SECURITY NO. 577-07-1259  |   |  |                  | 17. INFORMANT Ruth L. Jones  |                            |                           |                            | Address Same as # 2   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]   |  |                  |                |  |   |  |                  |  |                            |                           |                            |   |  |  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Acute myocardial infarction<br>4201<br>DUE TO<br>Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last: (b) Hypertensive cardiovascular disease |  |                  |                |  |   |  |                  |  |                            |                           |                            | INTERVAL BETWEEN ONSET AND DEATH immediate                          |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |                  |                |  |   |  |                  |  |                            |                           |                            | 1 yr +  |  |  |  |
| 20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                  |                | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)           |   |  |                  |  |                            |                           |                            |   |  |  |  |
| 20c. TIME OF INJURY   |  | Month, Day, Year | Hour a.m. p.m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |                  | 20f. (City or town)  |                            | (County)                  | (State)                    |   |  |  |  |
| 19  |  |                  |                |  |   |  |                  |  |                            |                           |                            |   |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from 3-15, 1967, to 4-7, 1967, that (I) (we) last saw the deceased alive on 4-7, 1967, and that death occurred at 4201 M, from the causes and on the date stated above.        |  |                  |                |  |   |  |                  |  |                            |                           |                            |   |  |  |  |
| 22a. SIGNATURE Martin T. Kim MD   |  |                  |                | 22b. DATE SIGNED APR 10 1967   |   |  |                  |  |                            |                           |                            |   |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) MARTIN T. KIM MD.  |  |                  |                | 22d. ADDRESS SHADY SIDE, MD  |   |  |                  |  |                            |                           |                            |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial  |  |                  |                | 23b. DATE THEREOF 4-10-1967  |   |  |                  | 23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill                      |                            |                           |                            | 23d. LOCATION (City, town or county) (State) Suitland Prince Geo Md |  |  |  |
| 24. FUNERAL DIRECTOR  |  |                  |                | ADDRESS  |   |  |                  | 25a. REC'D BY REGISTRAR  |                            |                           |                            | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| Matthew J. Finn Home, 131 1/2 St. N.E. Wash, D.C.   |  |                  |                |  |   |  |                  | DATE APR 10 1967   |                            |                           |                            | Signature   |  |  |  |

Debtors - 2000

18250

25000 = 10000

+ 10000 = 35000

10000 + 10000 = 20000  
20000 + 10000 = 30000

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**M**

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04584

CERTIFICATE OF DEATH

04586

|  |  |  |   |  |   |
|--|--|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> |   |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b>   | c. LENGTH OF STAY IN 1b<br><b>9 days</b>   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Pasadena</b>                  | d. STREET ADDRESS<br><b>Route 2 - Box 290</b>                                       |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Crownsville State Hospital</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |   |  |   |
| 3. NAME OF DECEASED<br>(Type or print) #35241  | First<br><b>William</b>  | Middle<br><b>E.</b>  | Last<br><b>Jones</b>  |  |   |
| 4. DATE OF DEATH<br><b>4 27 1967</b>   | Month<br>4   | Doy<br>27  | Year<br>1967  |  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED<br>WIDOWED <input type="checkbox"/><br>DIVORCED <input type="checkbox"/>                                  | 8. DATE OF BIRTH<br><b>11/1/09</b>  |  |   |
| 9. AGE (In years last birthday)<br><b>57 yrs.</b>  | IF UNDER 1 YEAR<br>Months<br>Days<br>Hours<br>Min.   | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Carpenter</b>      | 10b. KIND OF BUSINESS OR INDUSTRY<br>-----  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>North Carolina</b> | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |
| 13. FATHER'S NAME<br><b>Unknown</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   |   |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>Unk.</b>   | 16. SOCIAL SECURITY NO.<br><b>220-18-4655</b>  | 17. INFORMANT<br><b>Hospital Records</b>   | Address   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (o)<br><b>Myocardial Insufficiency</b><br>1/201<br>DUE TO<br>(b) Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost.<br>DUE TO<br>(c) <b>Organizing Myocardial Infarct; Thrombosed Occlusion of Left Coronary Artery</b> |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)<br><b>Massive Encephalomalacia of left Cerebral Hemisphere</b>  |  |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>-----  |  |   |  | 20f. (City or town) (County) (State)  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. ----- P.M. 19  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>-----                                      |   |  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>4/18/1967</b> to <b>4/27/1967</b> , that (I) (we) last saw the deceased alive on <b>4/27/1967</b> , and that death occurred at <b>5:10</b> M, from causes and on the date stated above.   |  |  |   |  | 22b. DATE SIGNED<br><b>4/27/67</b>  |
| 22a. SIGNATURE<br><i>Benedict</i>  | M.D. ATTENDING PHYS. <input type="checkbox"/>  | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                               | 22b. DATE SIGNED<br><b>4/27/67</b>  |  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>L. Benedict, M.D.</b>   | 22d. ADDRESS<br><b>Crownsville State Hospital, Md.</b>   |  |   |  |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>5-1-1967</b>   | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>Glen Haven Memorial Pk.</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Ritchie Hwy., A.A. Co., Md.</b> |  |   |
| 24. FUNERAL DIRECTOR<br><b>George J. Gonce-4001 Ritchie Hwy., Baltimore</b>  | ADDRESS  | 25a. REC'D BY REGISTRAR<br><b>MAY 3 1967</b>   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                                  |  |   |

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22490

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

04585

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04587

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

*M*  
State Department of Health

|  |                              |  |   |  |  |  |  |  |  |  |  |  |  |
|--|------------------------------|--|---|--|--|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>A.A.CO.</b>   |                              | MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>MD</b> |  | b. COUNTY<br><b>MONTGOMERY</b>                                       |  |  |  |  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>ANNAPOLIS -</b>   |                              | c. LENGTH OF STAY IN 1b  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SAN JUAN CAGUANATON</b> |  | d. STREET ADDRESS<br><b>10925 AMHERST AVE.</b>                       |  |  |  |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>O.O.A-Anne Arundel General</b>  |                              |  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>              |  |  |  |  |  |  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)   |                              | First<br><b>SAMUEL</b>   | Middle<br><b>KATZ</b>   | Last<br><b>KATZ</b>  | 4. DATE OF DEATH<br><b>4 26 1967</b>                 | Month<br><b>4</b>  | Doy<br><b>26</b>                       | Year<br><b>1967</b>  |  |  |  |  |  |
| 5. SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED<br>WIDOWED <input type="checkbox"/>   | NEVER MARRIED<br>DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>9-9-27</b>  | 9. AGE (In years<br>lost birthday)<br><b>39 yrs.</b> | IF UNDER 1 YEAR<br>Months<br><b>39</b>                               | IF UNDER 24 HRS.<br>Hours<br><b>39</b> |  |  |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Officer</b>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. NAVY</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>D.C.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                        |  |  |  |  |  |  |  |
| 13. FATHER'S NAME<br><b>DAVID KATZ</b>   |                              | 14. MOTHER'S MAIDEN NAME<br><b>GOLDIE KONSTAN</b>  |   | Address  |  |  |  |  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>YES</b>  |                              | 16. SOCIAL SECURITY NO.<br><b>55-14-049</b>  |   | 17. INFORMANT<br><b>Hospital Records</b>   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b>                    |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>multiple injuries</b><br>8254 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a).<br>stating the underlying cause (b) _____<br>DUE TO<br>last. (c) _____   |                              |  |   |  |  |  |  |  |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                              |  |   |  |  |  |  |  |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                              |  |   |  |  |  |  |  |  |  |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Auto accident Route 258</b> |   | 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m.<br><b>4 26 1967</b>  |  |  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Highway</b> |  | 20f. (City or town) (County) (State)<br><b>A.A.CO MD</b> |  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                              |  |   |  |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br><b>E. Linhardt</b>   |                              | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   | M.D.   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  | 22. DATE SIGNED<br><b>4-26-67</b>  |  |  |  |
| EXAMINER'S NAME (Type)<br><b>E. Linhardt</b>   |                              | Address (Street, city, town, or county)  |   |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL APR 26, 67</b>  |                              | 23b. DATE THEREOF<br><b>APR 26, 67</b>   |   | 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS<br><b>ARLINGTON NATIONAL</b>                                      |  | 23d. LOCATION (City or Town) (County) (State)<br><b>ARLINGTON VA</b> |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Harold P. Wash, Laurel, Md.</b>   |                              |  |   | 25a. REC'D BY REGISTRAR<br><b>Charles Judge</b>  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |  |  |
|  |                              |  |   | DATE APR 28 1967   |  |  |  |  |  |  |  |  |  |

18610

222

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04586

## CERTIFICATE OF DEATH

04588

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |                              |  |  |
|--|------------------------------|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY<br><i>Anne Arundel</i>  |                              | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE<br><i>Maryland</i>   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |                              | c. LENGTH OF STAY IN lb<br><i>293 m.</i>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><i>Crownsville State Hosp</i>  |                              | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First<br><i>Edith</i>  |                              | Middle<br><i>G.</i>  | 4. DATE OF DEATH<br>Lost<br><i>Kemp</i> Month<br><i>4</i> Doy<br><i>22</i> Year<br><i>1967</i>                 |
| 5. SEX<br><i>F</i>   | 6. COLOR OR RACE<br><i>W</i> | 7. MARRIED<br>WIDOWED <input checked="" type="checkbox"/>  | NEVER MARRIED <input type="checkbox"/><br>DIVORCED <input type="checkbox"/>                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><i>Maryland</i>   |                              | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  |
| 13. FATHER'S NAME<br><i>Richard Alexander Tarr</i>   |                              | 14. MOTHER'S MAIDEN NAME<br><i>Martha Roberts Brooks</i>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, unknown) <i>No</i>  |                              | 16. SOCIAL SECURITY NO.<br><i>None</i>   |  |
| 17. INFORMANT<br><i>Crownsville State Hospital Records</i>   |                              | Address  |  |
| IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |                              |  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Hypertension pneumonia</i> DUE TO <i>4/20/67</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Ischemic heart de.</i> DUE TO <i>2-3 p.m.</i><br>(c) |                              |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                              |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m.<br>p.m. 19   |                              | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <i>4/20/67</i> , 19 to <i>4/21/67</i> , 19, that (I) (we) last saw the deceased alive on <i>4/20/67</i> , 19, and that death occurred at <i>3:15 A.M.</i> from causes and on the date stated above.  |                              |  |  |
| 22a. SIGNATURE<br><i>Murphy</i>  |                              | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                                      | 22b. DATE SIGNED<br><i>4/21/67</i>   |
| 22c. PHYSICIAN'S NAME (Type)<br><i>L. BEVERLY M.D.</i>   |                              | 22d. ADDRESS<br><i>Crownsville State Hospital</i>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |                              | 23b. DATE THEREOF<br><i>4/25/1967</i>  | 23c. NAME OF CEMETERY OR CREMATORIUM<br><i>Lorraine Park Cemetery</i>  |
| 24. FUNERAL DIRECTOR<br><i>Wm. J. Tidman &amp; Sons Mortuary</i>   |                              | ADDRESS<br><i>Baltimore, Md.</i>   | 25a. REC'D BY REGISTRAR<br>DATE APR 24 1967  |
|  |                              |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |

88540

1970-30-1111851

88540

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04587

## CERTIFICATE OF DEATH

04589

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |   |  |   |   |  |  |  |
|--|---|--|---|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>b. STATE <b>Maryland</b>  |   |   |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b>   | c. LENGTH OF STAY IN lb<br><b>23 days</b> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>1059 Gay Street</b>   | d. STREET ADDRESS<br><b>Baltimore</b>   |   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Crownsville State Hospital</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |   |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>#34945 George</b>  | First <b>T.</b>                           | Middle <b>King</b>   | 4. DATE OF DEATH<br>Month <b>4</b> Day <b>9</b> Year <b>1967</b>                                  |   |  |  |  |
| S. SEX <b>Male</b>   | 6. COLOR OR RACE <b>White</b>             | 7. MARRIED<br>NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>                          | 8. DATE OF BIRTH<br><b>12/14/85</b>   | 9. AGE (In years<br>last birthday)<br><b>82</b> yrs.  | IF UNDER 1 YEAR<br>Months <b>0</b> Dofs <b>0</b> | IF UNDER 24 HRS.<br>Hours <b>0</b> Min. <b>0</b> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Unemployed</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br>-----   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Washington, D.C.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>       |  |
| 13. FATHER'S NAME<br><b>Charles H. King</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Tolbert</b>   |   |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO.<br><b>213-34-7782</b>  |   | 17. INFORMANT <b>Mr. Geo. McMathis Jr.</b> <small>Address</small><br><b>Hospital Records 10 Light St. Balt. Md.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)  |   | PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (o) <b>491X</b>  |   | INTERVAL BETWEEN ONSET AND DEATH<br>Bronchopneumonia  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last.   |   | (b) <b>-----</b><br>DUE TO<br>(c) <b>-----</b>   |   |   |  |  |  |
| 20a. MEDICAL CERTIFICATION   |   | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)                               |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>-----  |   |   |  |  |  |
| 20c. TIME OF INJURY Month, Doy, Year<br>Hour o.m.<br>----- p.m. -----  |   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>-----                   | 20f. (City or town) <b>-----</b><br>(County) <b>-----</b><br>(State) <b>-----</b>   |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>3/18/1967</b> , to <b>4/9/1967</b> , that (I) (we) last saw the deceased alive on <b>4/9/1967</b> , and that death occurred at <b>3:45 P.M.</b> , from causes and on the date stated above. |   | 22a. SIGNATURE<br><i>Henry Sander</i>  |   | M.D. <b>-----</b> ATTENDING PHYS. <input type="checkbox"/> P. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/><br>22b. DATE SIGNED <b>4/10/67</b> |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>L. Benedict, M.D.</b>   |   | 22d. ADDRESS<br><b>Crownsville State Hospital, Md.</b>   |   |   |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>4/13/67</b>       | 23c. NAME OF CEMETERY OR CREMATORIUM<br><b>Baltimore Cemetery</b>  | 23d. LOCATION (City or Town) <b>Baltimore</b><br>(County) <b>Maryland</b><br>(State) <b>-----</b> |   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Henry Sander &amp; Sons Inc. Baltimore Md.</b>  |   | ADDRESS<br><b>-----</b>  | 25a. REC'D BY REGISTRAR<br><b>APR 12 1967</b>   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |  |  |

42250

WILSON COUNCIL

42250

Debtors

Debtors - 1981

1981

Debtors - 1982

Debtors - 1983

Debtors - 1984

Debtors - 1985

Debtors - 1986

Debtors - 1987

Debtors - 1988

Debtors - 1989

Debtors - 1990

Debtors - 1991

Debtors - 1992

Debtors - 1993

Debtors - 1994

Debtors - 1995

Debtors - 1996

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04588

## CERTIFICATE OF DEATH

04590

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><br>Anne Arundel MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><br>Maryland Anne Arundel  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Glen Burnie Baltimore Maryland   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Brooklyn Belto, Md - 21225                  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>North Arundel Glen Burnie, Md.   |  | d. STREET ADDRESS<br>105 W. Hilltop Road  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | e. DATE OF DEATH<br>507 Month April Doy 22 Year 1967  |  |
| 3. NAME OF DECEASED (Type or print)<br>First Edwin C. Koehnle  |  | 4. DATE OF DEATH<br>Month April Doy 22 Year 1967  |  |
| 5. SEX<br>Male W   |  | 6. COLOR OR RACE<br>WIDOWED   |  |
| 7. MARRIED<br>X NEVER MARRIED <input type="checkbox"/><br>DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br>10-23-02  |  |
| 100. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Ret. Tavern Mgr.  |  | 9. AGE (In years lost birthday) IF UNDER 1 yr.<br>64 yrs. Months Doy Hours Min.   |  |
| 10b. KIND OF BUSINESS OR INDUSTRY<br>Tavern Restaurant   |  | 11. BIRTHPLACE (County & State, or foreign country)<br>Maryland (Baltimore)   |  |
| 13. FATHER'S NAME<br>Edwin Koehnle   |  | 12. CITIZEN OF WHAT COUNTRY?<br>United States   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <input type="checkbox"/> If yes give war or dates of service<br>1/6   |  | 16. SOCIAL SECURITY NO.<br>123-45-6789  |  |
| 17. INFORMANT<br>Mrs. Carolyn C. Koehnle (nick) Stone  |  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>443X<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>(b) DUE TO<br>(c) DUE TO |  | INTERVAL BETWEEN ONSET AND DEATH<br>Acute heart failure<br>Cerebro-vascular hemorrhage<br>Hypertension Cardiac vascular disease |  |
| 20a. MEDICAL CERTIFICATION<br>ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)    |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. P.M. 19  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work                       |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from 4/16, 1967, to 4/22, 1967, that (I) (we) last saw the deceased alive on 4/22, 1967, and that death occurred at 1285P M, from causes and on the date stated above.                                      |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               |  |
| 22a. SIGNATURE<br>Guillermo S. Linsao  |  | 22b. DATE SIGNED<br>4-22-67   |  |
| 22c. PHYSICIAN'S NAME (Type)<br>Guillermo S. LINSAO  |  | 22d. ADDRESS<br>7308-Furnace Branch Rd Glen Burnie  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 23b. DATE THEREOF Tues Apr 25-67  |  |
| 23c. NAME OF CEMETERY OR CREMATORIAL<br>Western Cemetery   |  | 23d. LOCATION (City or Town) (County) (State)<br>Balto Md.  |  |
| 24. FUNERAL DIRECTOR<br>CURTIS E. EVANS  |  | ADDRESS 6005 S. 21st Street   |  |
|  |  | 25a. REC'D BY REGISTRAR<br>APR 25 1967  |  |
|  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |

49

2323

1  
FOR STATE  
HEALTH DEPT.

Please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained by your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04583

04591

1. PLACE OF DEATH

a. COUNTY  
ANNE ARUNDEL

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Ft. MEADE, MD

c. LENGTH OF STAY IN lb

DOA

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

KIMBROUGH ARMY HOSPITAL

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

HILDA

M

KOHR

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

B. DATE OF BIRTH

Oct. 1, 1899

9. AGE (In years  
last birthday)

67

yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Never Worked

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Tremont, Penna

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

William Krebbs

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give rank or details of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Mrs. Kenneth Hattel, Hanover, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (e)

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(e), stating the underlying  
cause last.

(b)

DUE TO

(c)

*uterous cancer*

INTERVAL BETWEEN  
ONSET AND DEATH

*several*

19. WAS AUTOPSY  
PERFORMED?

YES  NO

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING   
CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m.  10 p.m.

20d. INJURY OCCURRED  
White  Not White   
at work  at work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion  
death resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

DATE SIGNED

APR. 19-1967

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

22b. DATE THEREOF

April 12, 1967 Reform Cemetery

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)

(State)

Tremont, Schuylkill Co., Penna.

23. FUNERAL DIRECTOR

Benny E. Hyatt

ADDRESS

Hopping Funeral Home 172 West St., Annapolis, MD APR 11 1967

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

Charles Judge

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04590

## CERTIFICATE OF DEATH

04592

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after the funeral  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>A.A. Co.</b>  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b>  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Glen Burnie</b>   |   | c. LENGTH OF STAY IN 1b<br><b>3 days</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>North Arundel Hospital</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Wilbert</b>   |   | First<br><b>W.</b>  | Middle<br><b>Kramer</b>   |
| 4. DATE OF DEATH<br><b>April 15 1967</b>   | Month<br><b>Month</b>   | Doy<br><b>15</b>  | Year<br><b>1967</b>   |
| 5. SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>W</b>  | 7. MARRIED<br><input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                          | 8. DATE OF BIRTH<br><b>Feb. 7, 1913</b>                                   |
| 9. AGE (In years<br>last birthday)<br><b>54 yrs.</b>   | 10. IF UNDER 1 YEAR<br>Months<br><b>0</b>                               | 11. IF UNDER 24 HRS.<br>Days<br><b>0</b>  | 12. Hours<br><b>0</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br><b>Printer</b>   | 10b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>Schneldereitt &amp; Sons</b> | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Md.</b>  | 12. CITIZEN OF WHAT<br>COUNTRY?<br><b>USA</b>                             |
| 13. FATHER'S NAME<br><b>Unknown - Kramer</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Anna Kittle</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b>   | 16. SOCIAL SECURITY NO.<br><b>213-01-2512</b>                           | 17. INFORMANT<br><b>Minnie M. Kramer - Wife - Same as #2</b>  | Address   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |   | INTERVAL BETWEEN<br>ONSET AND DEATH   |   |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>4/20/1</b>   |   | <i>Gangrenous myocardial infarction</i><br><b>1 day</b>   |   |
| Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last.<br><b>Arteriosclerotic heart disease</b>   |   | <i>Arteriosclerotic heart disease</i><br><b>years</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m.<br>p.m.<br><b>April 15 1967</b>  |   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                          | 20e. PLACE OF INJURY (Home, farm,<br>factory, street, office bldg., etc.) |
| 21. I certify that (I) (this hospital) attended the deceased from <b>4/12</b> , 1967, to <b>4-15</b> , 1967, thot (I) (we) last<br>saw the deceased alive on <b>4/15</b> , 1967, and thot death occurred at <b>6:00 AM</b> , from causes and on the date stated above. |   | 20f. (City or town) <b>Baltimore</b> (County) <b>Maryland</b> (State)   |   |
| 22a. SIGNATURE<br><i>Adam J. Murphy</i>  |   | M.D. <input type="checkbox"/> ATTENDING PHYS.<br><b>MD</b> <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.<br><b>MD</b> <input type="checkbox"/> | 22b. DATE SIGNED<br><b>4-15-67</b>  |
| 22c. PHYSICIAN'S NAME (Type)   |   | 22d. ADDRESS  |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>  |   | 23b. DATE THEREOF<br><b>4/18/67</b>   | 23c. NAME OF CEMETERY OR CREMATORIUM<br><b>Mt. Carmel Cemetery</b>        |
| 24. FUNERAL DIRECTOR<br><i>Robert P. Ware</i><br><b>Singleton Funeral Home/Glen Burnie, Md.</b>  |   | ADDRESS   | 25a. REC'D BY REGISTRAR<br><b>APR 17 1967</b>                             |
|  |   |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                        |

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

04591

**CERTIFICATE OF DEATH**

04593

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel MARYLAND</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> b. COUNTY<br><b>Anne Arundel</b> |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>   |  | c. LENGTH OF STAY IN 1b<br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>                       |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Anne Arundel General Hospital</b>   |  | d. STREET ADDRESS<br><b>950 West St.,</b>   |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Cora M. KRAUSE</b>  |  | First<br><b>Cora</b>  | Middle<br><b>M.</b>   |
| 4. DATE OF DEATH<br>Month<br><b>April</b>  | Day<br><b>27</b>   | Year<br><b>1967</b>   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED<br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | NEVER MARRIED <input type="checkbox"/>                                      |
| 8. DATE OF BIRTH<br><b>May 12, 1878</b>  | 9. AGE (In years<br>last birthday<br><b>88</b> )   | 10. IF UNDER 1 YEAR<br>Months<br><b>88</b>  | 11. IF UNDER 24 HRS.<br>Days<br>Hours<br>Min.                               |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br><b>EXECUTIVE RET.</b>  | 10b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>RETAIL AUTO</b>   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>New York</b>  |   |
| 12. CITIZEN OF WHAT<br>COUNTRY?<br><b>U.S.</b>   |  |   |   |
| 13. FATHER'S NAME<br><b>FENIMORE J. KEELER</b>   | 14. MOTHER'S MAIDEN NAME<br><b>LAURA GAMBY</b>   |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>  | 16. SOCIAL SECURITY NO.  | 17. INFORMANT<br><b>ANDREW KRAUSE JR. DUBOIS Rp. 214C</b>   | Address   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>Cerebral artery thrombosis</b><br>DUE TO<br><b>4221</b><br>(b) <b>Perforating Cerebral Arteries</b><br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last.<br>DUE TO<br>(c) |  |   |   |
| INTERVAL BETWEEN<br>ONSET AND DEATH<br><b>12 days.</b>   |  |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Hour a.m.<br>p.m.<br><b>19</b>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm,<br>factory, street, office bldg., etc.)   | 20f. (City or town)<br>(County)<br>(State)                                  |
| 21. I certify that (I) ( <b>Richard N. Peeler</b> ) attended the deceased from _____, 19_____, to <b>Apr. 27, 1967</b> , that (I) ( <b>John M. Taylor &amp; Sons</b> ) last saw the deceased alive on <b>Apr. 27, 1967</b> , and that death occurred at _____, Md., from causes and on the date stated above.  |  |   |   |
| 22a. SIGNATURE<br><b>Richard N. Peeler</b>   |  | 22b. DATE SIGNED<br><b>9:20 AM 4/27/67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Richard N. Peeler, M.D.</b>   | 22d. ADDRESS<br><b>121 Cathedral St., Annapolis, Md.</b>   | M.D. <input checked="" type="checkbox"/> ATTENDING PHYS.<br>MED. DIRECTOR <input type="checkbox"/><br>STAFF PHYS. <input type="checkbox"/>            |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE THEREOF<br><b>4/30/1967</b>  | 23c. NAME OF CEMETERY OR CREMATORIUM<br><b>HILLCREST CEM.</b>   | 23d. LOCATION (City or Town)<br>(County)<br>(State)<br><b>ANNAPOLIS MD.</b> |
| 24. FUNERAL DIRECTOR<br><b>JOHN M. TAYLOR &amp; SONS ANNAPOLIS MD.</b>   | ADDRESS  | 25a. REC'D BY REGISTRAR<br>DATE<br><b>Charles Judge</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>MAY 1 1967</b>                             |

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AM 81394-1, 2002, 2003, 2004

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04592

CERTIFICATE OF DEATH

04594

|   |  |   |   |  |  |                                      |
|---|--|---|---|--|--|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>b. STATE<br><b>Maryland</b> Anne Arundel     |   |  |  |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Millersville</b>   | c. LENGTH OF STAY IN lb<br><b>3 mos</b>  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Pasadena</b>                                   | d. STREET ADDRESS<br><b>Magothy Beach</b>   |  |  |                                      |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Knollwood Manor Nursing Home</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                     |   |  |  |                                      |
| 3. NAME OF DECEASED<br>(Type or print)  | First<br><b>Charles</b>  | Middle<br><b>E.</b>   | 4. DATE OF DEATH<br>Month<br><b>April</b> Day<br><b>18</b> Year<br><b>19 67</b>   |  |  |                                      |
| 5. SEX<br><b>M</b>  | 6. COLOR OR RACE<br><b>W</b>   | 7. MARRIED<br>NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>31 July 1882</b>   |  |  |                                      |
| 9. AGE (In years last birthday)<br><b>84</b> yrs.   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Car Repairman (ret)</b>                           | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |                                      |
| 13. FATHER'S NAME<br><b>Unknown</b>   | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   | Address   |   |  |  |                                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>   | 16. SOCIAL SECURITY NO.<br><b>705-07-9341</b>  | 17. INFORMANT<br><b>Verno Frame, Pasadena, Md. (Att)</b>  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary edema</b><br>4201 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a).<br>stating the underlying cause (b) <b>Congestive Heart failure</b><br>lost. DUE TO<br>(c) <b>myocardial infarction</b> |  |  |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)<br><b>osteoarthritis and arterosclerosis</b>   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b>  |  |  |                                      |
| 20a. MEDICAL CERTIFICATION  | 20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. 19   |   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work                               | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 1</b> , 19 <b>67</b> , to <b>April 18</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>April 1</b> , 19 <b>67</b> , and that death occurred at <b>1</b> AM, from causes and on the date stated above. |  | 22. SIGNATURE<br><b>R. M. Smith</b>   |   | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22d. DATE SIGNED<br><b>4/19/67</b>                                     |                                      |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Ray M. Smith, M. D.</b>  | 23b. ADDRESS<br><b>Hahn Professional Bldg., Severna PK., Md.</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>   |  |  |                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>21 Apr. 1967</b>   | 23c. NAME OF CEMETERY OR CREMATORIALY<br><b>Parkwood Cemetery</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>   |  |  |                                      |
| 24. FUNERAL DIRECTOR<br><b>R. V. Singleton</b>  | ADDRESS<br><b>Glen Burnie, Md.</b>   | 25a. REC'D BY REGISTRAR<br><b>APR 20 1967</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |                                      |

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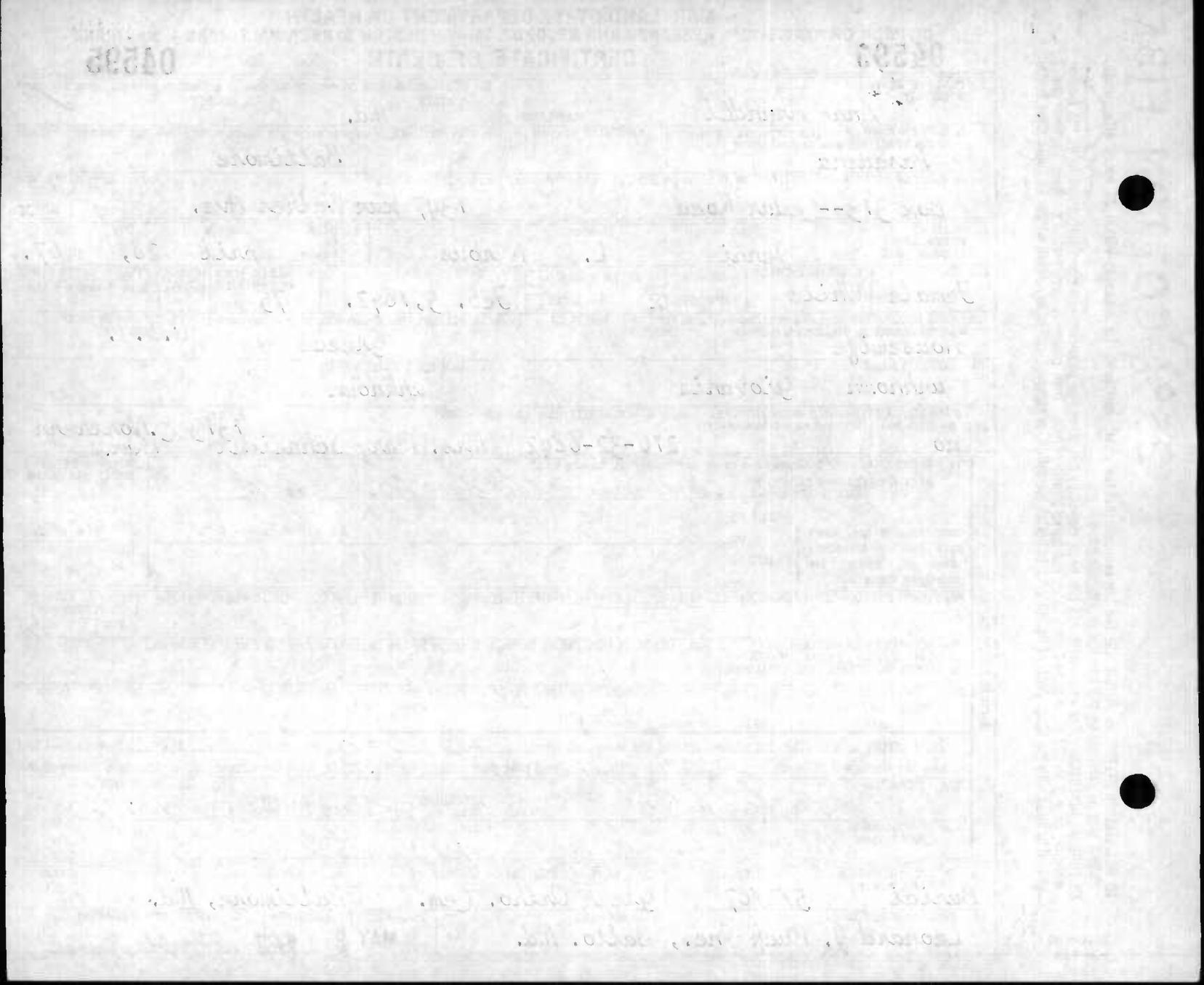
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |   |   |  |  |  |     |  |   |                                  |   |   |   |   |  |                       |                         |
|--|--|---|---|--|--|--|-----|--|---|----------------------------------|---|---|---|---|--|-----------------------|-------------------------|
| CERTIFICATE OF DEATH   |  |   |   |  |  | 04595  |     |  |   |                                  |   |   |   |   |  |                       |                         |
| 1. PLACE OF DEATH<br>a. COUNTY<br><i>Anne Arundel</i>  |  |   |   |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><i>Md.</i>                      |     |  |   |                                  |   |   |   |   |  |                       |                         |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Pasadena</i>  |  |   |   |  |  | c. LENGTH OF STAY IN 1b<br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Baltimore</i>      |     |  |   |                                  |   |   |   |   |  |                       |                         |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><i>Box 313--Cedar Road</i>   |  |   |   |  |  | d. STREET ADDRESS<br><i>1347 Hale Walker Ave.</i>  |     |  |   |                                  |   |   |   |   |  |                       |                         |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |   |  |  |  |     |  |   |                                  |   |   |   |   |  |                       |                         |
| 3. NAME OF DECEASED<br>(Type or print)   |  | First<br><i>Jennie</i>                        | Middle<br><i>L.</i>   | Last<br><i>Kyrous</i>                        | 4. DATE OF DEATH<br><i>April 28, 1967.</i> | Month  | Day | Year   | 5. SEX<br><i>Female</i>                                       | 6. COLOR OR RACE<br><i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>Feb. 5, 1892.</i>  | 9. AGE (In years last birthday)<br><i>75 yrs.</i> | 10. IF UNDER 1 YEAR<br>Months<br><i>0</i> | 11. IF UNDER 24 HRS.<br>Days<br><i>0</i>           | 12. Hours<br><i>0</i> | 13. Minutes<br><i>0</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>  |  |   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><i></i> |  |  |     | 11. BIRTHPLACE (County & State, or foreign country)<br><i>Greece</i> |   |                                  |   | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |   |   |  |                       |                         |
| 13. FATHER'S NAME<br><i>unknown</i>  |  |   |   |  |  | 14. MOTHER'S MAIDEN NAME<br><i>Giovanis</i>  |     |  |   |                                  |   |   |   |   |  |                       |                         |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><i>no</i>  |  | 16. SOCIAL SECURITY NO.<br><i>216-32-6842</i> |   | 17. INFORMANT<br><i>Mrs. Mary Schneider</i>  |  | Address<br><i>1313 E Northern Pkwy</i>   |     |  |   |                                  |   |   |   |   |  |                       |                         |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Carcinoma of the left breast with metastases</i>   |  |   |   |  |  |  |     |  |   |                                  |   | INTERVAL BETWEEN ONSET AND DEATH<br><i>1 year</i>   |   |   |  |                       |                         |
| 170X<br>Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.<br><i></i>  |  |   |   | DUE TO<br>(b) _____<br>DUE TO<br>(c) _____   |  |  |     |  |   |                                  |   |   |   |   |  |                       |                         |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)<br><i>none</i>  |  |   |   |  |  |  |     |  |   |                                  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |   |  |                       |                         |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |   |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)<br><i></i>                              |     |  |   |                                  |   |   |   |   |  |                       |                         |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m.<br>p.m.<br><i>19</i>   |  |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><i></i>  |     |  | 20f. (City or town)<br><i></i>                                |                                  |   | (County)<br><i></i>   |   |   | (State)<br><i></i>                                 |                       |                         |
| 21. I certify that (I) (this hospital) attended the deceased from <i>2/23</i> , 1967, to <i>4/28</i> , 1967, that (I) (we) last saw the deceased alive on <i>4/27</i> , 1967, and that death occurred at <i>6 P.M.</i> from the causes and on the date stated above. |  |   |   |  |  |  |     |  |   |                                  |   | 22b. DATE SIGNED<br><i>4/27/67</i>  |   |   |  |                       |                         |
| 22a. SIGNATURE<br><i>R.W. McLaughlin</i>   |  |   |   |  |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |     |  |   |                                  |   | 22b. DATE SIGNED<br><i>4/27/67</i>  |   |   |  |                       |                         |
| 22c. PHYSICIAN'S NAME (Type)<br><i>R.W. McLaughlin</i>   |  |   |   |  |  | 22d. ADDRESS<br><i>3708 Mountain Rd. Pasadena, Md.</i>   |     |  |   |                                  |   |   |   |   |  |                       |                         |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |  |   | 23b. DATE THEREOF<br><i>5/2/67</i>  |  |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br><i>Greek Ortho. Cem.</i>   |     |  | 23d. LOCATION (City, town or county)<br><i>Baltimore, Md.</i> |                                  |   | (State)   |   |   |  |                       |                         |
| 24. FUNERAL DIRECTOR<br><i>Leonard J. Ruck Inc., Balto. Md.</i>  |  |   |   |  |  | ADDRESS  |     |  |   |                                  |   | 25a. REC'D BY REGISTRAR<br>DATE<br><i>MAY 3 1967</i>  |   |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i> |                       |                         |

2650

1968



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

04594

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04596

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>A.A.</u><br>MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MD.</u><br>b. COUNTY <u>A.A.</u>                       |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>  |   | c. LENGTH OF STAY IN lb   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A.A. GENERAL</u>   |   | d. STREET ADDRESS <u>RIVA</u>   |   |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |   |
| 3. NAME OF DECEASED<br>(Type or print)   | First <u>JOHN</u> Middle <u>FRANKLIN</u> Last <u>LEE</u>  |   | 4. DATE OF DEATH<br>Month <u>4</u> Day <u>18</u> Year <u>1967</u>                             |
| 5. SEX <u>M</u>  | 6. COLOR OR RACE <u>W</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11-14-1963</u>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>  |   |
| 11. BIRTHPLACE (State or foreign country) <u>Annapolis</u>   |   | 12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>   |   |
| 13. FATHER'S NAME <u>JAMES E. LEE</u>  | 14. MOTHER'S MAIDEN NAME <u>MARJORIE CLAYTON</u>  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  | 16. SOCIAL SECURITY NO. <u>—</u>  | 17. INFORMANT <u>JAMES E. LEE #2</u>  | Address <u>—</u>  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (o) <u>9298</u> DUE TO <u>Bravery</u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO <u>—</u> (c) <u>—</u>  |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)   |   |   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Tell from our</u>   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>4/18</u> 19 <u>67</u><br>p.m. <u>—</u>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/><br>at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Our Home</u>  | 20f. (City or town) <u>Annapolis</u> (County) <u>Anne Arundel</u> (State) <u>MD.</u>          |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |   |   |   |
| ACTUAL SIGNATURE <u>John E. Lee</u>  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   | 22. DATE SIGNED <u>4-18-67</u>  |
| EXAMINER'S NAME (Type) <u>E. Lee Garrett</u>   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |   |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   | Address (Street, city, town, or county) <u>Annapolis, A.A., MD.</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  | 23b. DATE THEREOF <u>4-20-67</u>  | 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <u>St. Anne's</u>  | 23d. LOCATION (City or Town) <u>Annapolis</u> (County) <u>Anne Arundel</u> (State) <u>MD.</u> |
| 24. FUNERAL DIRECTOR <u>John McFay &amp; Sons</u>  | 25a. REC'D BY REGISTRAR <u>APR 24 1967</u>  |   | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>   |



To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |  |  |   |  |   |  |                         |                              |         |   |
|---|--|--|--|--|---|--|---|--|-------------------------|------------------------------|---------|---|
| CERTIFICATE OF DEATH  |  |  |  |  |   |  |   |  |                         |                              |         |   |
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b>   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Anne Arundel</b> |   |  |   |  |                         |                              |         |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>  |  |  |  | c. LENGTH OF STAY IN 1b<br><b>1 day</b>  |   |  |   |  |                         |                              |         |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>U. S. Naval Hospital</b>   |  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |  |   |  |                         |                              |         |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Elizabeth Waite</b>  |  |  |  | First  | Middle  | Last   | 4. DATE OF DEATH<br><b>April 19 1967</b>          | Month  | Day                     | Year                         |         |   |
| 5. SEX<br><b>Female</b>   |  |  |  | 6. COLOR OR RACE<br><b>Cauc</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>23 Mar 1892</b>                                 | 9. AGE (In years last birthday)<br><b>75 yrs.</b> | IF UNDER 1 YEAR<br>Months  | IF UNDER 24 HRS<br>Days | Hours                        | Min.    |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>N/A</b>  |   |  |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Worcester, Massachusetts</b> |                         |                              |         | 12. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |
| 13. FATHER'S NAME<br><b>Francis L. Waite</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Alice E. Thompson</b>   |   |  |   |  |                         |                              |         |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>yes</b>   |  |  |  | 16. SOCIAL SECURITY NO.<br><b>220-48-8754</b>  |   |  |   | 17. INFORMANT<br><b>Audrey Elizabeth Ogden</b>   |                         |                              |         | Address<br><b>Box 54 - Herald Harbor, Crownsville</b> |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b>   |  |  |  | Md.<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>20 HRS</b>   |   |  |   |  |                         |                              |         |   |
| 4201<br>Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  | DUE TO<br>(b) <b>ARTERIOSCLEROTIC HEART DISEASE</b><br>DUE TO<br>(c) <b>CARCINOMA OF THE CERVIX</b>  |   |  |   |  |                         |                              |         | <b>15 YEARS</b>                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |  |  |  |   |  |   |  |                         |                              |         |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |  |   |  |                         |                              |         |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m.<br>p.m. 19  |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   | 20f. (City or town) <b>Annapolis</b>   |                         | (County) <b>Anne Arundel</b> | (State) |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>18 April 1967</b> , to <b>19 April 1967</b> , that (I) <b>never</b> last saw the deceased alive on <b>19 April 1967</b> , and that death occurred at <b>1:26 PM</b> the causes and on the date stated above. |  |  |  |  |   |  |   |  |                         |                              |         |   |
| 22a. SIGNATURE<br><b>Barry J. Coughlin, LT</b>  |  |  |  | 22b. DATE SIGNED<br><b>19 April 67</b>   |   |  |   |  |                         |                              |         |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Barry J. Coughlin, LT MC USNR U. S. Naval Hospital, Annapolis, Md.</b>   |  |  |  | 22d. ADDRESS   |   |  |   |  |                         |                              |         |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |  |  | 23b. DATE THEREOF<br><b>April 22, 1967</b>   |   | 23c. NAME OF CEMETERY OR CREMATORIUM<br><b>St. Anne's Cemetery</b>     |   | 23d. LOCATION (City, town or county) (State)<br><b>Annapolis, Anne Arundel Md.</b>     |                         |                              |         |   |
| 24. FUNERAL DIRECTOR <b>Beverly E. Hopping</b>  |  |  |  | ADDRESS<br><b>HOPPING FUNERAL HOME - Annapolis, Maryland</b>   |   | 25a. REC'D BY REGISTRAR<br><b>APR 24 1967</b>                          |   | 25b. REGISTRAR'S SIGNATURE<br><b>J Charles Judge</b>                                   |                         |                              |         |   |

Lebanon, Ohio

Analyses

Lebanon, Ohio

effluvium

No. 1

effluvium

ground water - No. 6

Indirect levelling

Level

Water

Water

Water

51

500 feet

500

feet

Lebanon, Ohio - elevation 500 feet

at noon

water level ground

surface ground water

bottom - 500 feet

150 feet

different roads using different grades

500

Lebanon, Ohio - Elevation 500 feet

500 feet

Lebanon, Ohio

To find 500

500 feet - Indirect levelling - U.S. Army Corps of Engineers - 1930

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                  |  |   |        |  |                  |  |     |   |   | 04598   |      |  |  |                                      |  |  |  |  |  |
|---|--|------------------|--|---|--------|--|------------------|--|-----|---|---|---|------|--|--|--------------------------------------|--|--|--|--|--|
| CERTIFICATE OF DEATH  |  |                  |  |   |        |  |                  |  |     |   |   | 04598   |      |  |  |                                      |  |  |  |  |  |
| 1. PLACE OF DEATH   |  |                  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)           |        |  |                  |  |     |   |   |   |      |  |  |                                      |  |  |  |  |  |
| a. COUNTY   |  | Anne Arundel     |  | MARYLAND  |        | a. STATE   |                  | Maryland   |     | b. COUNTY                                   |   | Anne Arundel  |      |  |  |                                      |  |  |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  |  | Annapolis        |  | c. LENGTH OF STAY IN lb   |        | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) |                  | Annapolis  |     |   |   |   |      |  |  |                                      |  |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  |  |                  |  | 130 Lafayette Ave.,   |        |  |                  |  |     |   |   | d. STREET ADDRESS   |      | 130 Lafayette Ave.,                    |  |                                      |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print)   |  |                  |  | First   | Middle | Last   | 4. DATE OF DEATH | Month  | Day | Year  | e. IS RESIDENCE ON A FARM?  |   |      |  |  |                                      |  |  |  |  |  |
| LEON  |  |                  |  | Martin  | LIPMAN | Mar. 4, 1902   | April            | 10   | 19  | 67  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |      |  |  |                                      |  |  |  |  |  |
| 5. SEX  |  | 6. COLOR OR RACE |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>           |        | 8. DATE OF BIRTH   |                  | 9. AGE (In years last birthday)                                |     | IF UNDER 1 YEAR                             |   | IF UNDER 24 HRS.  |      |  |  |                                      |  |  |  |  |  |
| male  |  | white            |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                              |        | Mar. 4, 1902   |                  | 65 yrs.  |     | Months                                      | Days  | Hours   | Min. |  |  |                                      |  |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  |                  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |        |  |                  | 11. BIRTHPLACE (County & State, or foreign country)            |     |   |   | 12. CITIZEN OF WHAT COUNTRY?  |      |  |  |                                      |  |  |  |  |  |
| proprietor  |  |                  |  | retail clothing   |        |  |                  | Annapolis Maryland   |     |   |   | USA   |      |  |  |                                      |  |  |  |  |  |
| 13. FATHER'S NAME   |  |                  |  |   |        |  |                  |  |     |   |   | 14. MOTHER'S MAIDEN NAME  |      |  |  |                                      |  |  |  |  |  |
| Joseph Lipman   |  |                  |  |   |        |  |                  |  |     |   |   | Bessie Weitzman   |      |  |  |                                      |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |  |                  |  | 16. SOCIAL SECURITY NO.   |        |  |                  | 17. INFORMANT  |     |   |   | Address   |      |  |  |                                      |  |  |  |  |  |
| no  |  |                  |  | 218-32-1898   |        |  |                  | Mrs. Anne Lipman - same as #2 above                            |     |   |   |   |      |  |  |                                      |  |  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]   |  |                  |  |   |        |  |                  |  |     |   |   | INTERVAL BETWEEN ONSET AND DEATH                                    |      |  |  |                                      |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Angina Pectoris<br>14203 DUE TO   |  |                  |  |   |        |  |                  |  |     |   |   | 26 yrs.   |      |  |  |                                      |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (b)<br>(c), stating the underlying cause last.   |  |                  |  |   |        |  |                  |  |     |   |   |   |      |  |  |                                      |  |  |  |  |  |
| DUE TO  |  |                  |  |   |        |  |                  |  |     |   |   |   |      |  |  |                                      |  |  |  |  |  |
| DUE TO  |  |                  |  |   |        |  |                  |  |     |   |   |   |      |  |  |                                      |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |                  |  |   |        |  |                  |  |     |   |   | 19. WAS AUTOPSY PERFORMED?  |      |  |  |                                      |  |  |  |  |  |
| Congestive heart failure, grade I   |  |                  |  |   |        |  |                  |  |     |   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |      |  |  |                                      |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m.<br>p.m.   |  |                  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> at work <input type="checkbox"/> |        | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)           |                  | 20f. (City or town)  |     | (County)                                    |   | (State)   |      |  |  |                                      |  |  |  |  |  |
| 19  |  |                  |  |   |        |  |                  |  |     |   |   |   |      |  |  |                                      |  |  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from 2-20-67 to 4-10-67, 1967, that (I) (we) last saw the deceased alive on 4-10-1967 and that death occurred at 9:50 P.M. from the causes and on the date stated above. |  |                  |  |   |        |  |                  |  |     |   |   | 22b. DATE SIGNED<br>4-11-67   |      |  |  |                                      |  |  |  |  |  |
| 22e. SIGNATURE<br>Frank M. Shipley, M.D.  |  |                  |  |   |        |  |                  |  |     |   |   | ATTENDING PHYS. <input checked="" type="checkbox"/>                 |      | MED. DIRECTOR <input type="checkbox"/> |  | STAFF PHYS. <input type="checkbox"/> |  |  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)  |  |                  |  |   |        |  |                  |  |     |   |   | 22d. ADDRESS<br>121 Cathedral St., Annapolis, Md.                   |      |  |  |                                      |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  |                  |  | 23b. DATE THEREOF<br>April 12, 1967   |        |  |                  | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Hebrew Friendship Cem. |     |   |   | 23d. LOCATION (City, town or county)<br>Baltimore                   |      | (State)<br>Maryland                    |  |                                      |  |  |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br>E. hopping<br>HOPPING FUNERAL HOME - Annapolis, Maryland  |  |                  |  | ADDRESS<br>Bentley E. hopping   |        |  |                  | 25. REC'D. BY REGISTRAR<br>APR 13 1967                         |     | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge |   |   |      |  |  |                                      |  |  |  |  |  |
| YR A15 (4)<br>20M S-63  |  |                  |  |   |        |  |                  |  |     |   |   |   |      |  |  |                                      |  |  |  |  |  |

01238

01238

~~FOR STATE  
HEALTH DEPT.~~

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04597

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04599

|   |                           |   |  |   |   |
|---|---------------------------|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><br>Anne Arundel MARYLAND   |                           | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><br>Maryland A. A.   |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><br>Annapolis   |                           | b. COUNTY   |  |   |   |
| c. LENGTH OF STAY IN lb   |                           | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><br>Deale   |  |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><br>Anne Arundel General Hospital   |                           | d. STREET ADDRESS<br>5211 Route 1   |  |   |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                           |   |  |   |   |
| 3. NAME OF DECEASED<br>(Type or print)  |                           | First CLAYTON   | Middle A.  |   |   |
| Last LOWRY  |                           | 4. DATE OF DEATH<br>Month April Doy 26 Year 1967  |  |   |   |
| S. SEX<br>Male  | 6. COLOR OR RACE<br>White | 7. MARRIED<br>WIDOWED <input type="checkbox"/>  | NEVER MARRIED <input checked="" type="checkbox"/><br>DIVORCED <input type="checkbox"/> |   |   |
| 8. DATE OF BIRTH<br>Nov. 27, 1915   |                           | 9. AGE (In years lost birthday)<br>51 yrs.  |  |   |   |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Painter   |                           | 11. BIRTHPLACE (State or foreign country)<br>Washington, D. C.  |  |   |   |
| 12. CITIZEN OF WHAT COUNTRY?  |                           |   |  |   |   |
| 13. FATHER'S NAME<br>William B. Lowry   |                           | 14. MOTHER'S MAIDEN NAME<br>Ella Graves   |  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br>Yes World War II  |                           | 16. SOCIAL SECURITY NO.<br>17. INFORMANT Address<br>Mrs. Evelyn Lowry same address  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 816.4<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a).<br>stating the underlying cause (b)<br>DUE TO<br>(c)<br>last.   |                           |   |  | INTERVAL BETWEEN ONSET AND DEATH  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                           |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 20a. EXTERNAL CAUSE WAS<br>PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)<br>Driver in auto-auto collision   |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour and p.m. 4 26 1967   |                           | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>Street       | 20f. (City or town)<br>Bristol  | (County) (State)<br>A.A. Md.                |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                           |   |  |   |   |
| ACTUAL SIGNATURE<br>Charles S. Petty  |                           | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/> |  | 22. DATE SIGNED<br>4/27/67  |   |
| EXAMINER'S NAME (Type)<br>Charles S. Petty  |                           | Address (Street, city, town, or county)   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Removal  |                           | 23b. DATE THEREOF<br>4/27/1967  | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Balto. Md.                                     | 23d. LOCATION (City or Town)<br>Washington, D. C.   | (County) (State)                            |
| 24. FUNERAL DIRECTOR<br>Wm. J. Tishman & Sons Mortuary  |                           | ADDRESS   |  | 25a. REC'D BY REGISTRAR<br>D MAY 1 1967   | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge |

Q220

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Exhibit

150

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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M

34598

04600

CERTIFICATE OF DEATH

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |   |  |   |
|--|---|--|---|
| 1. PLACE OF DEATH<br>o. COUNTY<br><b>Anne Arundel</b>  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE<br><b>Maryland</b>   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>   |   | c. LENGTH OF STAY IN lb<br><b>45 Min.</b>  |   |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>RURAL - Edgewater</b>   |   | d. STREET ADDRESS<br><b>Rt-4, Box-331-F</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Anne Arundel General Hospital</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Infant Edward M.</b>  |   | First<br><b>Edward</b>   | Middle<br><b>M.</b>   |
| 4. DATE OF DEATH<br><b>LYNCH Jr.</b>   | Month<br><b>April</b>                     | Doy<br><b>10</b>   | Year<br><b>1967</b>   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>          | 7. MARRIED<br><input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>April 10, 1967</b>   |
| 9. AGE (In years lost birthday)<br>yrs.<br><b>0</b>  | 10. IF UNDER 1 YEAR<br>Months<br><b>0</b> | 11. IF UNDER 24 HRS<br>Dys<br><b>42</b>  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Newborn</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY  |   |
| 13. FATHER'S NAME<br><b>Edward M. Lynch</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Marion Robinson Lynch</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO.<br><b>None</b>   |   |
| 17. INFORMANT<br><b>Mr. Edward M. Lynch</b>  |   | Address<br><b>Rt. 4 Box 331 F Edgewater</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>751.1</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause }<br>DUE TO (b) <b>Spiral Bony, Multiple Congenital</b><br>DUE TO (c) <b>Cataractes</b> |   |  |   |
| INTERVAL BETWEEN ONSET AND DEATH<br><b>45 M.N.</b>   |   |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)   |   |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m.<br>p.m.<br><b>19</b>   |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Rowe Blvd., Annapolis, Md.</b> |
| 21. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from <b>Apr. 10, 1967</b> to <b>Apr. 10, 1967</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>Apr. 10, 1967</b> , and that death occurred at <b>M.</b> from causes and on the date stated above.               |   | 22b. DATE SIGNED<br><b>3:17 AM 4/10/67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Francis M. Kopack, M.D.</b>   |   | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/><br>MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                        | 22d. ADDRESS<br><b>Rowe Blvd., Annapolis, Md.</b>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |   | 23b. DATE THEREOF<br><b>Apr 11 1967</b>  | 23c. NAME OF CEMETERY OR CREMATORIUM<br><b>Ft. Lincoln Cemetery</b>   |
| 24. FUNERAL DIRECTOR<br><b>Beall Funeral Home</b>  |   | 23d. LOCATION (City or Town)<br><b>Bladensburg</b>   | (County) <b>Pr. Georges</b><br>(State)  |
|  |   | 25a. ADDRESS<br><b>1212 West St.</b>   | 25b. REC'D BY REGISTRAR<br><b>APR 11 1967</b>   |
|  |   | 25c. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   |

00919

ACCE

Labour, etc.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04593

## CERTIFICATE OF DEATH

06131

|  |                                    |  |  |  |   |
|--|------------------------------------|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b> MARYLAND   |                                    |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b>   |                                    | c. LENGTH OF STAY IN lb<br><b>2 months</b>   |  | d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>LaPlata</b> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Crownsville State Hospital</b>  |                                    |  | e. STREET ADDRESS  |  |   |
| 3. NAME OF DECEASED<br>(Type or print) <b>#34748 Ruby</b>  |                                    |  | First <b>Lynch</b>   | Middle <b></b>   | Last <b></b>  |
| 4. DATE OF DEATH<br><b>4 4 67</b>  | Month <b>4</b>                     | Doy <b>30</b>  | Year <b>1967</b>   | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED<br>WIDOWED <input type="checkbox"/><br><b>X</b> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>2/26/11</b>   | 9. AGE (In years lost birthday)<br><b>56 yrs.</b>  | IF UNDER 1 YEAR<br>Months <b></b> Dofs <b></b> Hours <b></b> Min. <b></b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                    | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>                             |   |
| 13. FATHER'S NAME<br><b>Edward M. Della</b>  |                                    |  | 14. MOTHER'S MAIDEN NAME<br><b>Ryce (Sophia)</b>   |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b>   |                                    | 16. SOCIAL SECURITY NO.<br><b>None</b>   |  | 17. INFORMANT<br><b>Hospital Records</b> Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart Failure and uremia</b> INTERVAL BETWEEN ONSET AND DEATH<br>443X<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a).<br>stating the underlying cause lost.<br>(b) <b>Hypertensive Cardiovascular Disease</b><br>DUE TO<br>(c) <b>Marked Arteriolonephro-sclerosis</b> |                                    |  |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                                    |  |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>-----  |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m.<br>----- 14 P.M.   |                                    | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>-----                                      | 20f. (City or town) <b>Crownsville</b> (County) <b>Md.</b> (State)                                 |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>2/27</b> , 1967, to <b>4/30</b> , 1967, that (I) (we) last saw the deceased alive on <b>4/30</b> , 1967, and that death occurred at <b>M</b> , from causes and on the date stated above.  |                                    |  |  |  |   |
| 22a. SIGNATURE<br><i>Benedict</i>  |                                    | 22b. DATE SIGNED<br>M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <b>5/2/67</b>    |  |  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>L. Benedict, M. D.</b>  |                                    | 22d. ADDRESS<br><b>Crownsville State Hospital, Maryland</b>  |  |  |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>5/8/67</b> | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>711 E Emory</b>   |  | 23d. LOCATION (City or Town) <b>Crownsville</b> (County) <b>Md.</b> (State)                        |   |
| 24. FUNERAL DIRECTOR<br><b>Richard Funeral Home, Inc. La Plata, MD</b>   |                                    | ADDRESS<br><b>Richard Funeral Home, Inc. La Plata, MD</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE<br><b>MAY 9 1967</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                        |

00131

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04600

CERTIFICATE OF DEATH

04601

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><br>Anne Arundel MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission).<br>a. STATE Maryland b. COUNTY ANNAPOLIS       |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Annapolis   |   | c. LENGTH OF STAY IN lb<br>4 days   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>Anne Arundel General Hospital   |   | e. STREET ADDRESS<br>1333 Hull St.,   |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |   |
| 3. NAME OF DECEASED<br>(Type or print)  | First<br>Guiseppina   | Middle<br>Josephine   | Last<br>MARCELLINO  |
| 4. DATE OF DEATH<br>Month April<br>Day 26<br>Year 1967  |   |   |   |
| S. SEX<br>Female  | 6. COLOR OR RACE<br>White   | 7. MARRIED<br>WIDOWED <input checked="" type="checkbox"/>   | NEVER MARRIED <input type="checkbox"/><br>DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH<br>Feb. 25, 1884   | 9. AGE (In years<br>83<br>last birthday)<br>yrs.  | 10. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br>Housewife                            | 11. BIRTHPLACE (County & State, or foreign country)<br>Italy                |
| 12. CITIZEN OF WHAT COUNTRY?<br>Italy   |   | 13. FATHER'S NAME<br>August Russo   | 14. MOTHER'S MAIDEN NAME<br>Unknown   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) No   | 16. SOCIAL SECURITY NO.<br>216-54-1515T   | 17. INFORMANT<br>Norman Marcellino  | Address<br>1330 Hull St.,   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION<br>DUE TO<br>200X<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) ARTERIOSCLEROTIC HEART DISEASE<br>DUE TO<br>stating the underlying cause (c) DIABETES<br>DUE TO<br>UNKNOWN<br>UNKNOWN<br>UNKNOWN |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)<br>TERMINAL HYPOSTATIC BRONCHIOPNEUMONIA  |   |   |   |
| 20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m.<br>p.m. 19  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (Arthur Lankford Jr., M.D.) attended the deceased from JAN, 1967, to Apr. 26, 1967 that (I) (Arthur Lankford Jr., M.D.) last saw the deceased alive on Apr. 26, 1967, and that death occurred at M, from causes and on the date stated above.  |   |   |   |
| 22a. SIGNATURE<br>Arthur Lankford Jr., M.D.   | M.D.  | ATTENDING PHYS. <input checked="" type="checkbox"/><br>MED. DIRECTOR <input type="checkbox"/><br>STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED<br>1:05 PM   |
| 22c. PHYSICIAN'S NAME (Type)<br>Arthur Lankford, Jr., M.D.  | 22d. ADDRESS<br>2934 Mountain Road, Pasadena, Md.   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   | 23b. DATE THEREOF<br>5/1/67   | 23c. NAME OF CEMETERY<br>Most Holy Redeemer   | 23d. LOCATION (City or Town)<br>Baltimore, Md. (County) (State)             |
| 24. FUNERAL DIRECTOR<br>Charles L. Stevens Funeral Home, INC.   | ADDRESS<br>1501 East Fort Avenue.   | 25a. REC'D BY REGISTRAR<br>DATE MAY 1 1967  | 25b. REGISTRAR'S SIGNATURE<br>jCharles Judge                                |

10010

Hudson Standard

00240

Leather cap

Black leather

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04602

|   |  |  |  |   |   |
|---|--|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><i>A.A.</i>   | MARYLAND   | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>a. STATE<br><i>MARYLAND</i>   | b. COUNTY<br><i>A.A.</i>   |   |   |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><i>Rural Glen Burnie</i>  | c. LENGTH OF STAY IN 1b  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><i>Glen Burnie</i>   | d. STREET ADDRESS<br><i>1121 Crain Hwy</i>   |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><i>North Arundel Hospt.</i>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |   |
| 3. NAME OF DECEASED<br>(Type or print)  | First<br><i>WALTER T.</i>  | Middle<br><i>MARTIN</i>  | 4. DATE OF DEATH<br>Month<br><i>Sept</i> Day<br><i>9</i> Year<br><i>1967</i>   |   |   |
| 5. SEX<br><i>M</i>  | 6. COLOR OR RACE<br><i>C</i>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>            | 8. DATE OF BIRTH<br><i>4/15/1887</i>   |   |   |
| 9. AGE (In years last birthday)<br>yrs.<br><i>79</i>  | 10. KIND OF BUSINESS OR INDUSTRY<br><i>Chandler (Ret.)</i>   | 11. BIRTHPLACE (County & State, or foreign country)<br><i>Mt Pleasant</i>  | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |   |   |
| 13. FATHER'S NAME<br><i>Abraham Martin</i>  | 14. MOTHER'S MAIDEN NAME<br><i>Isabelle Rideout</i>  | Address<br><i>1121 Crain Hwy</i>   |  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><i>No</i>   | 16. SOCIAL SECURITY NO.<br><i>180-26-1358</i>  | 17. INFORMANT<br><i>Flourna Martin - 1121 Crain Hwy</i>  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><i>4201</i> DUE TO<br>Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.<br><i>Cerebral Hemorrhage</i> (b) DUE TO<br><i>Hypertensive CardioRenal Disease</i> (c) DUE TO<br><i>Congestive Occlusion</i> |   |   |
| INTERVAL BETWEEN ONSET AND DEATH<br><i>10 days</i>  |  |  |  |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |  |  |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |   |   |
| 20a. MEDICAL CERTIFICATION  | 20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20d. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |   | 20f. (City or town) (County) (State)                                  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m.<br>p.m.   | 19   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                        |   |
| 21. I certify that (I) (this hospital) attended the deceased from <i>2-10-</i> , 19 <i>66</i> , to <i>4-8-</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>4-8- 1967</i> , and that death occurred at <i>341 M</i> , from the causes and on the date stated above. | 22a. SIGNATURE<br><i>Richard H. Hunt</i>   | 22b. DATE SIGNED<br><i>4-10-67</i>   |  |   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><i>Richard H. Hunt</i>  | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          | 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   | 23b. DATE THEREOF<br><i>4/15/67</i>  | 23c. NAME OF CEMETERY OR CREMATORIAL<br><i>Western Star</i> | 23d. LOCATION (City, town or county) (State)<br><i>Catonsville Md</i> |
| 24. FUNERAL DIRECTOR<br><i>Turnell B. Oden - Balt Md 21217</i>  | ADDRESS  | 25a. REC'D BY REGISTRAR<br><i>APR 12 1967</i>  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles J. Gray</i>   |   |   |

90020

10020

FOR STATE  
HEALTH DEPT.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04603

|   |                        |   |  |   |  |  |                                  |
|---|------------------------|---|--|---|--|--|----------------------------------|
| 1. PLACE OF DEATH<br>o. COUNTY Anne Arundel MARYLAND  |                        |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE Maryland b. COUNTY Anne Arundel |  |  |                                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Glen Burnie</b>  |                        | c. LENGTH OF STAY IN lb<br><b>D.O.A.</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Brooklyn</b>                               |  | d. STREET ADDRESS<br><b>422 Old Riverside Road</b> |                                  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>North Arundel Hospital (DOA)</b>   |                        |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 |  |  |                                  |
| 3. NAME OF DECEASED<br>(Type or print)  | First Shirley J.       | Middle McCracken  | Last   | 4. DATE OF DEATH  | Month April 21                                     | Doy  | Year 1967                        |
| 5. SEX Female   | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | B. DATE OF BIRTH<br><b>Feb. 8, 1928</b>                                |   | 9. AGE (In years last birthday) <b>39</b> yrs.     | IF UNDER 1 YEAR Months                             | IF UNDER 24 HRS. Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                        | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Rockford, Ill.</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>          |                                  |
| 13. FATHER'S NAME<br><b>J. Henderson</b>  |                        |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Biah Larson</b>  |  |  |                                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b>  |                        | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><b>Mr. Blair G. McCracken Jr.</b>  |  | Address <b>Same</b>                                |                                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> INTERVAL BETWEEN ONSET AND DEATH<br>4200<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a).<br>stating the underlying cause (b) _____<br>last.<br>DUE TO<br>(c) _____  |                        |   |  |   |  |  |                                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                        |   |  |   |  |  |                                  |
| 2D. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                        | 2D. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)   |  |   |  |  |                                  |
| 2Dc. TIME OF INJURY Month, Day, Year<br>Hour a.m.<br>p.m. 19  |                        | 2Dd. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   | 2Df. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   | 2Df. (City or town)                                | (County)   | (State)                          |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                        |   |  |   |  |  |                                  |
| ACTUAL SIGNATURE<br><i>Charles S. Springate</i>   |                        | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>Address (Street, city, town, or county)<br>4-22-67 |  |   |  |  |                                  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                        | 23b. DATE THEREOF<br><b>April 25, 1967</b>  | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>Baltimore Nat. Cem.</b>     | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>   |  |  |                                  |
| 24. FUNERAL DIRECTOR<br><b>George J. Gonce</b>  |                        | ADDRESS<br><b>4001 Ritchie Hwy. Balto. Md.</b>  | 25a. REC'D BY REGISTRAR<br><b>APR 26 1967</b>                          |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i> |  |                                  |

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**TO DEPUTY MEDICAL EXAMINER:** Please execute the certificate of death. **TO FUNERAL DIRECTOR:** Page 4 shall be retained for your files. **TO FUNERAL DIRECTOR:** Page 3 shall be retained for your files. **Health:** Prior to burial, cremation, or

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6M 1/67

60000

300AC

business opportunities. We are in great demand for our services.  
We are looking forward to your prompt response.

FOR STATE  
HEALTH DEPT.

1  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

2  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04604

04603

|   |   |  |                                    |  |  |   |   |                               |  |
|---|---|--|------------------------------------|--|--|---|---|-------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>A. N. CO.</b>  |   | MARYLAND   |                                    | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Md</b> |  | b. COUNTY<br><b>ANACO</b>                           |   |                               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Glen Burnie</b>  |   | c. LENGTH OF STAY IN lb  |                                    | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Lombarday Beach</b>     |  | d. STREET ADDRESS<br><b>Rt 1 Box 164 Locust Rd</b>  |   |                               |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>D.O.N - NOrth - ARUNDEL</b>  |   |  |                                    | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>              |  |   |   |                               |  |
| 3. NAME OF<br>DECEASED<br>(Type or print)   |   | First<br><b>Daniel</b>   | Middle<br><b>R</b>                 | Lost   | 4. DATE<br>OF<br>DEATH<br><b>4 29 1967</b> | Month<br><b>4</b>                                   | Day<br><b>29</b>                          | Year<br><b>1967</b>           |  |
| 5. SEX<br><b>M</b>  | 6. COLOR OR RACE<br><b>W</b>            | 7. MARRIED<br><input checked="" type="checkbox"/> NEVER MARRIED<br><input type="checkbox"/> WIDOWED<br><input type="checkbox"/> DIVORCED                       | 8. DATE OF BIRTH<br><b>4/14/18</b> | 9. AGE (In years<br>last birthday)<br><b>49</b> yrs.   | 10. IF UNDER 1 YEAR<br>Months<br><b>0</b>  | 11. IF UNDER 24 HRS.<br>Days<br><b>0</b>            | 12. IF UNDER 24 HRS.<br>Hours<br><b>0</b> | Min.<br><b>0</b>              |  |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br><b>Stevedore</b>  |   | 10b. KIND OF BUSINESS OR<br>INDUSTRY   |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>Md</b>   |  | 12. CITIZEN OF WHAT<br>COUNTRY?<br><b>USA</b>       |   |                               |  |
| 13. FATHER'S NAME<br><b>Daniel McDougall</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Sophia Ankewitz</b>   |                                    | Address  |  |   |   |                               |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>Yes</b>  | 16. SOCIAL SECURITY NO.<br><b>WW 11</b> | 17. INFORMANT<br><b>Family</b>   | Same                               |  |  |   |   |                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral clonus</b><br>DUE TO<br><b>4344</b><br>Conditions, if any, which gave<br>rise to immediate cause (a).<br>stating the underlying cause<br>lost. (b) _____<br>DUE TO<br>(c) _____   |   |  |                                    |  |  |   |   |                               | INTERVAL BETWEEN<br>ONSET AND DEATH<br><b>deader</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |   |  |                                    |  |  |   |   |                               | 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH.   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                    |  |  |   |   |                               |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m.<br>p.m. 19  |   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |                                    | 20e. PLACE OF INJURY (Home, farm,<br>factory, street, office bldg., etc.)                                      |  | 20f. (City or town) (County) (State)                |   |                               |  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion<br>death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |   |  |                                    |  |  |   |   |                               | 22. DATE SIGNED<br><b>4-29-67</b>  |
| ACTUAL<br>SIGNATURE<br><b>D. L. Mull</b>  |   | M.D.   |                                    | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> |   |                               |  |
| EXAMINER'S<br>NAME (Type)<br><b>F. L. Shantz</b>  |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |                                    | Address (Street, city, town, or county)  |  |   |   |                               |  |
| 23a. BURIAL, CREMATION,<br>BURIAL (Specify)<br><b>Burial</b>  |   | 23b. DATE THEREOF<br><b>5/3/67</b>   |                                    | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>Balto Natl Cem</b>  |  | 23d. LOCATION (City or Town)<br><b>Catonsville</b>  |   | (County) (State)<br><b>Md</b> |  |
| 24. FUNERAL DIRECTOR<br><b>McCully F H 237 Patapsco Ave 21225</b>   |   | ADDRESS  |                                    | 25a. REC'D BY REGISTRAR<br><b>MAY 2 1967</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |                               |  |

10310

3082

attached

Enclosed

b

b

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04604

## CERTIFICATE OF DEATH

04605

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |                               |   |  |
|---|-------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <i>A-A-Co.</i><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>  |                               | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <i>Md</i><br>b. COUNTY <i>A-A-Co.</i><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Arnold</i> |  |
| 3. NAME OF DECEASED (Type or print) <i>JAMES G. McNAMARA</i>  |                               | 4. DATE OF DEATH<br>Month <i>4</i> Day <i>25</i> Year <i>1967</i>   |  |
| S. SEX <i>Male</i>  | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <i>8-29-27</i>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Came WADER STATE</i>  |                               | 9. AGE (In years last birthday) <i>39 yrs.</i>  |  |
| 13. FATHER'S NAME <i>Water W. McNamara</i>  |                               | 11. BIRTHPLACE (County & State, or foreign country) <i>CAMBRIDGE, Md USA</i>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>  |                               | 16. SOCIAL SECURITY NO. <i>WU 11</i>  |  |
| 17. INFORMANT <i>Helen McNamara - Alone</i>   |                               | 12. CITIZEN OF WHAT COUNTRY? <i>Address</i>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>myocardial infarction</i><br>4201<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>coronary artery occlusion</i><br>stating the underlying cause (c) <i>arteriosclerosis</i> |                               | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                               |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <i>19</i><br>p.m. <i></i>   |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) <i>Severna Park</i> (County) <i>Md</i> (State) <i></i>  |                               | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <i>10/22/66</i> to <i>4/25/67</i> , that (I) (we) last saw the deceased alive on <i>7-25-67</i> , and that death occurred at <i>4150 M</i> , from causes and on the date stated above.  |                               |   |  |
| 22a. SIGNATURE <i>Ron Smith</i>   |                               | 22b. DATE SIGNED <i>April 25, 1967</i>  |  |
| 22c. PHYSICIAN'S NAME (Type) <i>RAY M. SMITH</i>  |                               | 22d. ADDRESS <i>Severna Park, Md.</i>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial 4/28/67</i>   |                               | 23b. DATE THEREOF <i>4/28/67</i>  |  |
| 23c. NAME OF CEMETERY OR CREMATORIAL <i>Glen Haven</i>  |                               | 23d. LOCATION (City or Town) (County) (State) <i>Glen Haven, A.A. Co</i>  |  |
| 24. FUNERAL DIRECTOR <i>Robert S. Banacos, Severna Park, Md.</i>  |                               | ADDRESS <i>Robert S. Banacos, Severna Park, Md.</i>   |  |
| 25a. REC'D. BY REGISTRAR DATE <i>MAY 1 1967</i>   |                               | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>   |  |

00240

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04605

Items 18 &amp; 21 Film G-388 5/15/67 cac

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04606

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY Anne Arundel MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE Maryland   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie  | c. LENGTH OF STAY IN lb  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore   | d. STREET ADDRESS 5421 Springlake Way                              |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>North Arundel Hospital (DOA)  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) DANIEL J. MEARA   | First  | Middle   | 4. DATE OF DEATH April 21 Month 1967 Doy Year                      |
| S. SEX Male   | 6. COLOR OR RACE White   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6-12-1896 9. AGE (In years last birthday) 70 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Ass't. Mg. Editor  |  | 10b. KIND OF BUSINESS OR INDUSTRY Sunpapers  | 11. BIRTHPLACE (State or foreign country) N.J.                     |
| 13. FATHER'S NAME Edward F. Meara   |  | 14. MOTHER'S MAIDEN NAME Mary Cokely   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes   | 16. SOCIAL SECURITY NO. WWI  | 17. INFORMANT Robert A. Meara  | Address Balto., Md.  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 422, / DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } (b) _____<br>lost. _____ (c) _____   |  |  | INTERVAL BETWEEN ONSET AND DEATH _____                             |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m.<br>p.m. 19  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                               |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |  |
| ACTUAL SIGNATURE Charles S. Springate, M.D.   | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>Address (Street, city, town, or county) 4-22-67 |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial  | 23b. DATE THEREOF 4-24-67  | 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Parkwood  | 23d. LOCATION (City or Town) (County) (State) Parkville Md.        |
| 24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd., Balto.  | 25a. REC'D BY REGISTRAR APR 24 1967 25b. REGISTRAR'S SIGNATURE Charles J. Jenkins  |  |  |

2020

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                           |   |   |   |   |   |   |                          |       |      |  |
|--|---------------------------|---|---|---|---|---|---|--------------------------|-------|------|--|
| 04606  |                           |   |   |   |   | 04607   |   |                          |       |      |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>A.A. CO</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b><br>c. LENGTH OF STAY IN lb<br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>NORTH. ARUNDEL Hospital</b>   |                           |   |   |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>West Virginia</b><br>b. COUNTY <b>Nicholas</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Tioga - West - VA - 85-3</b><br>d. STREET ADDRESS<br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |                          |       |      |  |
| 3. NAME OF DECEASED (Type or print)<br><b>John H. MEARNS</b>   |                           | First   | Middle  | Last  | 4. DATE OF DEATH<br><b>4/12/67</b>  |   | Month   | Day                      | Year  |      |  |
| S. SEX <b>M</b>  | 6. COLOR OR RACE <b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | B. DATE OF BIRTH <b>April 28, 1898</b>                                      | 9. AGE (In years<br>In months<br>yrs.) <b>68</b>  | IF UNDER 1 YEAR<br>Months                       | IF UNDER 24 HRS.<br>Days | Hours | Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer (ret.)</b><br>10b. KIND OF BUSINESS OR INDUSTRY <b>(Self-Emp.)</b>   |                           |   |   |   | 11. BIRTHPLACE (State or foreign country) <b>Tioga, W. Virginia</b>         | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |   |                          |       |      |  |
| 13. FATHER'S NAME<br><b>Thomas J. Mearns</b>   |                           |   |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary Ella Curty</b>                          |   |   |                          |       |      |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |                           |   | 16. SOCIAL SECURITY NO. <b>Unknown</b>  |   | 17. INFORMANT<br><b>Ms. Anna Mary Dickerson (daughter) Glen Burnie, MD.</b> | Address   |   |                          |       |      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac disease</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a).<br>(b) _____<br>DUE TO<br>stating the underlying cause lost.<br>(c) _____   |                           |   |   |   |   |   |   |                          |       |      |  |
| INTERVAL BETWEEN ONSET AND DEATH <b>30 mins</b>  |                           |   |   |   |   |   |   |                          |       |      |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                           |   |   |   |   |   |   |                          |       |      |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                           |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |   |   |   |   |                          |       |      |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b><br>p.m.  |                           |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) <b>Tioga</b><br>(County) <b>W. Virginia</b><br>(State)  |   |   |                          |       |      |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                           |   |   |   |   |   |   |                          |       |      |  |
| ACTUAL SIGNATURE <b>E. Linhardt</b><br>EXAMINER'S NAME (Type) <b>E. Linhardt</b><br>M.D.   |                           |   |   |   |   |   |   |                          |       |      |  |
| CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county) <b>4-12-C7</b>  |                           |   |   |   |   |   |   |                          |       |      |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |                           | 23b. DATE THEREOF <b>April 15, 1967</b>   |   | 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Fairview Cemetery</b><br><b>Singleton Funeral Home</b><br><b>(Glen Burnie) MD</b> |   | 23d. LOCATION (City or Town) <b>Tioga</b><br>(County) <b>W. Virginia</b><br>(State)   |   |                          |       |      |  |
| 24. FUNERAL DIRECTOR <b>R.V. Singleton</b>   |                           |   |   |   |   | 25a. REC'D BY REGISTRAR <b>APR 14 1967</b>  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b> |                          |       |      |  |
| VR A15ME (5)<br>6M 1/66  |                           |   |   |   |   |   |   |                          |       |      |  |

१६ यमुना

Thermal T = 100 K and  $\epsilon_{\text{eff}} = 0.05$  (200-710)

*Musotima (Myosotis) rotundifolia* Schlecht. var. *hirsuta* Benth.

*to  
3*  
**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

*M*  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04607

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

04608

|  |                               |  |   |   |  |
|--|-------------------------------|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND  |                               |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>Anne Arundel</b> |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>   |                               | c. LENGTH OF STAY IN 1b<br><b>72 hours</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>IGLEHART Rural Annapolis</b> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>A. H Gen Hospt.</b>   |                               |  | d. STREET ADDRESS<br><b>RT. #1 Box 540</b>  |   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                               |  |   |   |  |
| 3. NAME OF DECEASED (Type or print) <b>EDMUND E. NALLEY</b>  |                               | First  | Middle  | Last  | 4. DATE OF DEATH<br>Month <b>APRIL</b> Day <b>5</b> Year <b>1967</b> |
| 5. SEX <b>MALE</b>   | 6. COLOR OR RACE <b>WHITE</b> | 7. MARRIED<br>WIDOWED <input type="checkbox"/>   | NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>Nov 1 1908</b>   | 9. AGE (In years last birthday) yrs.<br><b>58</b>                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>SUPERVISOR</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>BALTO GAS &amp; ELECTRIC CO., P.R. GEO. CO. MD</b>   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>EDWARD D. NALLEY</b>   |                               |  | 14. MOTHER'S MAIDEN NAME<br><b>LILLIAN BEALE</b>  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                               | 16. SOCIAL SECURITY NO.<br><b>-</b>  |   | 17. INFORMANT<br><b>HELEN M. NALLEY #2</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO <b>A.H.A.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO _____<br>(c) DUE TO _____ |                               |  |   |   |  |
| INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>  |                               |  |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                               |  |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b><br>p.m. <b>19</b>  |                               | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)<br><b>Annapolis</b>  | 20f. (City or town) <b>Annanpolis</b>   | (County) <b>Prince Geo. Co.</b> (State) <b>MD.</b>                   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Jan 18 1967</b> to <b>Apr 5 1967</b> , that (I) (we) last saw the deceased alive on <b>Jan 2 1967</b> , and their death occurred at <b>Annanpolis</b> M, from causes and on the date stated above.  |                               |  |   |   |  |
| 22a. SIGNATURE<br><i>E. Linhardt</i>   |                               | M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  | 22b. DATE SIGNED<br><b>Apr 5-67</b>   |   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>E. Linhardt</b>  |                               | 22d. ADDRESS <b>Annanpolis 2d</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL APR 8 1967</b>   |                               | 23b. DATE THEREOF <b>APR 8 1967</b>  | 23c. NAME OF CEMETERY OR CREMATORIAL <b>FORT LINCOLN Cem.</b>   | 23d. LOCATION (City or Town) (County) (State) <b>PRINCE GEO. CO. MD.</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>JOHN M. TAYLOR, Son Annapolis MD</b>  |                               | ADDRESS  | 25a. REC'D BY REGISTRAR<br><b>APR 10 1967</b>   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |
| VR A15 (4)<br>25M 1/67   |                               | DATE   |   |   |  |

02008

02008

WATER IS STAINED

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT!

04608

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04609

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |                                  |  |                                      |  |   |   |                                      |  |                   |   |                  |   |  |
|---|----------------------------------|--|--------------------------------------|--|---|---|--------------------------------------|--|-------------------|---|------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>ANNE ARUNDEL</b>   |                                  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>ANNAPOLIS</b>   |                                      | c. LENGTH OF STAY IN lb  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>b. COUNTY<br><b>Maryland</b> |                                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>HOLLY HILL HARBOR</b> |                   | d. STREET ADDRESS<br><b>EDGEMEATER</b>                                    |                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>A. A. GENERAL HOSPITAL - DOA</b>   |                                  | d. STREET ADDRESS  |                                      |  |   |   |                                      |  |                   |   |                  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)  |                                  | First<br><b>LEO</b>  | Middle<br><b>N.</b>                  | Last<br><b>NIMS S.</b>   | 4. DATE OF DEATH<br>Month<br><b>4-</b> Day<br><b>15</b> Year<br><b>1967</b> |   |                                      |  |                   |   |                  |   |  |
| S. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED<br><input checked="" type="checkbox"/> NEVER MARRIED<br><input type="checkbox"/> WIDOWED<br><input type="checkbox"/> DIVORCED                       | 8. DATE OF BIRTH<br><b>8-19-1914</b> | 9. AGE (In years last birthday)<br><b>52 yrs.</b>  | IF UNDER 1 YEAR<br>Months<br><b>52</b>                                      |   | IF UNDER 24 HRS.<br>Days<br><b>0</b> |  | HOURS<br><b>0</b> |   | MIN.<br><b>0</b> |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)<br><b>CIVIL SERVICE</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>CHAUFFEUR</b>  |                                      | 11. BIRTHPLACE (State or foreign country)<br><b>BRANDON, VT.</b>   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                                 |   |                                      |  |                   |   |                  |   |  |
| 13. FATHER'S NAME<br><b>GEORGE A. NIMS SR.</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>LILLIAN R. STONE</b>  |                                      | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no or unknown) (If yes give war or dates of service)<br><b>No</b> |   | 16. SOCIAL SECURITY NO.<br><b>-</b>   |                                      | 17. INFORMANT<br><b>Orville R. Nims #2</b>   |                   | Address   |                  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>Arteriosclerotic cardiovascular disease</b>   |                                  |  |                                      |  |   |   |                                      |  |                   |   |                  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| Conditions, if any, which gave rise to immediate cause (a).<br>stating the underlying cause<br>last.<br><b>4221</b>   |                                  | DUE TO<br>(b)<br><b>—</b>  |                                      | DUE TO<br>(c)<br><b>—</b>  |   |   |                                      |  |                   |   |                  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                  |  |                                      |  |   |   |                                      |  |                   |   |                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)   |                                      |  |   |   |                                      |  |                   |   |                  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m.<br>p.m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |                                      | 20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |                                      |  |                   |   |                  |   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                  |  |                                      |  |   |   |                                      |  |                   |   |                  |   |  |
| ACTUAL SIGNATURE<br><i>Werner U. Spitz</i>  |                                  | EXAMINER'S NAME (Type)<br><b>WERNER U. SPITZ, M.D.</b>   |                                      | M.D.   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |                                      | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>   |                   | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>                          |                  | 22. DATE SIGNED<br><b>4-16-67</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                  | 23b. DATE THEREOF<br><b>4-18-67</b>  |                                      | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>HILLCREST</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>ANNAPOLIS A.A. MD.</b>  |                                      | 23a. REC'D BY REGISTRAR<br><b>APR 18 1967</b>  |                   | 23b. REGISTRAR'S SIGNATURE<br><i>John M. Taylor, Esq., Annapolis, Md.</i> |                  |   |  |
| 24. FUNERAL DIRECTOR<br><b>John M. Taylor, Esq., Annapolis, Md.</b>   |                                  | ADDRESS  |                                      |  |   |   |                                      |  |                   |   |                  |   |  |

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04603

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

04610

|   |                                  |  |   |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> b. COUNTY<br><b>Anne Arundel</b>          |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b> c. LENGTH OF STAY IN lb<br><b>18 Mos.</b>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Pasadena</b> d. STREET ADDRESS<br><b>9 Brookfield Road</b>              |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Bay Mahor Nursing Home</b>   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>EDWIN</b> First<br><b>A.</b> Middle  |                                  | 4. DATE OF DEATH<br>Month<br><b>April</b> Day<br><b>10</b> Year<br><b>1967</b>   |   |
| S. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED<br><input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1 July 1885</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Mgr. (ret)</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Hdwe Store</b>   |   |
| 13. FATHER'S NAME<br><b>Joel E. Oakey</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>(Unknown)</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>17. INFORMANT<br/>Address<br/>Joel T. Oakey-Severna Park, Md.</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> INTERVAL BETWEEN ONSET AND DEATH<br>4301<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congestive heart failure</b> <b>few hours</b><br>DUE TO<br>(c) <b>Myocardial infarction</b> |                                  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Arteriosclerosis</b>   |                                  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m.<br>P.M. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>20f. (City or town) (County) (State)</b> |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Dec 11, 1965</b> , to <b>Apr 10, 1967</b> , that (I) (we) last saw the deceased alive on <b>Apr 5, 1967</b> , and that death occurred at <b>M</b> , from causes and on the date stated above.  |                                  |  |   |
| 22o. SIGNATURE<br><b>Ray M. Smith</b>   |                                  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                           | 22b. DATE SIGNED<br><b>Apr 12, 1967</b>   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Ray M. Smith, M. D.</b>  |                                  | 22d. ADDRESS<br><b>Severna Park, Maryland</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>13 Apr. 1967</b>   | 23c. NAME OF CEMETERY OR CREMATORIUM<br><b>Magothy Ch. Cemetery</b>   |
| 24. FUNERAL DIRECTOR<br><b>Singleton Funeral Home</b>   |                                  | ADDRESS<br><b>Glen Burnie, Md.</b>   | 25a. REC'D BY REGISTRAR<br><b>APR 14 1967</b>   |
|   |                                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 goes to the State Dept. of Health prior to burial, cremation, or removal, and in any event, should be filed with the State Dept. of Health.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04610

CERTIFICATE OF DEATH

04611

|   |                               |  |  |  |                                       |  |  |  |
|---|-------------------------------|--|--|--|---------------------------------------|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND   |                               |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Anne Arundel</b>       |  |                                       |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>   |                               | c. LENGTH OF STAY IN lb                            |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b> |                                       |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>North Arundel Hospital</b>  |                               |  | d. STREET ADDRESS <b>Rt 3 Box - 473(DuVall Hwy.)</b>   |  |                                       | e. IS RESIDENCE ON A FARM? <b>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>  |  |  |
| 3. NAME OF DECEASED (Type or print) <b>JOHN T. O'LEARY, JR.</b>   |                               | First <b>JOHN</b>                                  | Middle <b>T.</b>   | Lost   | 4. DATE OF DEATH <b>April 10 1967</b> | Month <b>April</b> Doy <b>10</b> Year <b>1967</b>  |  |  |
| S. SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <b>X NEVER MARRIED</b>                  | <input type="checkbox"/> WIDOWED   | <input type="checkbox"/> DIVORCED  | B. DATE OF BIRTH <b>May 11, 1892</b>  | 9. AGE (In years last birthday) <b>74</b> yrs.   | IF UNDER 1 YEAR <b>Months</b> <b>Days</b> <b>Hours</b> <b>Min.</b> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Bricklayer (ret)</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Self-Emp.</b> |  | 11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>                   |                                       |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                         |  |
| 13. FATHER'S NAME <b>John T. O'Leary, Sr.</b>   |                               |  | 14. MOTHER'S MAIDEN NAME <b>Agatha Taylor</b>  |  |                                       | Address  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>  |                               | 16. SOCIAL SECURITY NO. <b>217-09-3829</b>         |  | 17. INFORMANT <b>Curtis O'Leary</b>  |                                       | Same as # 2  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)   |                               |  | PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (o) <b>Congestive Heart Failure</b>  |  |                                       | INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>   |  |  |
| Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost.  |                               |  | (b) <b>Arteriosclerotic Cardio Vascular Disease</b>  |  |                                       | (c) <b>10 yrs.</b>   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)  |                               |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <b>Emphysema</b>  |  |                                       | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/> |  |                                       | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) <b>Riviera Beach, MD</b> (County) <b>Md.</b> (State) |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. <b>p.m.</b> <b>19</b>   |                               |  |  |  |                                       |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>April 6, 1967</b> to <b>April 10, 1967</b> , that (I) (we) last saw the deceased alive on <b>4/8 1967</b> , and that death occurred at <b>7:30A.M.</b> from causes and on the date stated above. |                               |  |  |  |                                       | 22b. DATE SIGNED <b>4/12/67</b>  |  |  |
| 22a. SIGNATURE <b>J. Brady Smith</b>  |                               |  | M.D. <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>              |  |                                       | 22d. ADDRESS <b>Riviera Beach, MD</b>  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>J. Brady Smith</b>  |                               |  |  |  |                                       |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                               | 23b. DATE THEREOF <b>13 Apr. 1967</b>              |  | 23c. NAME OF CEMETERY OR CREMATORIAL <b>Glen Haven Memorial Pk.</b>                              |                                       | 23d. LOCATION (City or Town) <b>Glen Burnie, Md.</b> (County) <b>Md.</b> (State)   |  |  |
| 24. FUNERAL DIRECTOR <b>R. P. Singleton</b><br><i>Singleton Funeral Home</i>  |                               |  | ADDRESS <b>Glen Burnie, Md.</b>  |  |                                       | 25a. REC'D BY REGISTRAR <b>APR 14 1967</b>   |  |  |
|   |                               |  |  |  |                                       | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |  |

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04611

CERTIFICATE OF DEATH

04612

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |                                  |  |  |  |                                       |  |                      |
|--|----------------------------------|--|--|--|---------------------------------------|--|----------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b> MARYLAND   |                                  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> |                                       |  |                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>   |                                  | c. LENGTH OF STAY IN lb  |  | b. COUNTY<br><b>Anne Arundel</b>   |                                       | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b> |                      |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Anne Arundel General Hospital</b>   |                                  |  |  | d. STREET ADDRESS<br><b>10 Gilmer Street</b>   |                                       |  |                      |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |  |  |  |                                       |  |                      |
| 3. NAME OF DECEASED<br>(Type or print)   | First<br><b>Martha</b>           | Middle<br><b>Ann</b>   | Last<br><b>PHELPS</b>                    | 4. DATE OF DEATH   | Month<br><b>April</b>                 | Doy<br><b>6</b>  | Year<br><b>19 67</b> |
| S. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>Negro</b> | 7. MARRIED<br><input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>June 25, 1922</b> | 9. AGE (In years last birthday)<br><b>44 yrs.</b>  | IF UNDER 1 YEAR<br>Months<br><b> </b> | IF UNDER 24 HRS.<br>Days<br><b> </b>   | Hours<br><b> </b>    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Clerk - U.S. Army Fort Meade</b>   |                                  |  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Annapolis Maryland</b>                                     |                                       |  |                      |
| 13. FATHER'S NAME<br><b>William Carroll</b>  |                                  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Lillie Snowden</b>  |                                       |  |                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>216-44-3071</b>  |  | 17. INFORMANT<br><b>William E. Phelps-10 Gilmer St. Anna. Md.</b> Address  |                                       |  |                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>acute peripheral Circulatory Collapse</i> DUE TO <b>3/25</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>status Asthmaticus</i> DUE TO <b>6 hours.</b><br>(c) |                                  |  |  |  |                                       |  |                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)   |                                  |  |  |  |                                       |  |                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |                                       |  |                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m.<br>p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                       | 20f. (City or town) (County) (State)   |                      |
| 21. I certify that (I) (this hospital) attended the deceased from <b>3/25</b> , 19 <b>67</b> , to <b>4/6</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>4/6</b> 19 <b>67</b> , and that death occurred at <b>3:04 A.M.</b> from causes and on the date stated above.   |                                  |  |  |  |                                       |  |                      |
| 22a. SIGNATURE<br><i>Richard N. Peeler</i>   |                                  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>   |  | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |                                       | 22b. DATE SIGNED<br><b>4/6/67</b>  |                      |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Richard N. Peeler, M.D.</b>   |                                  | 22d. ADDRESS<br><b>121 Cathedral St., Annapolis, Md.</b>   |  |  |                                       |  |                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>April 9-67</b>   |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>Carver Memorial</b>   |                                       | 23d. LOCATION (City or Town) (County) (State)<br><b>Laural, Maryland</b>                             |                      |
| 24. FUNERAL DIRECTOR<br><b>C.E.Hicks III Annapolis, Maryland</b>   |                                  |  |  | ADDRESS  |                                       | 25a. REC'D BY REGISTRAR<br><b>APR 10 1967</b>  |                      |
|  |                                  |  |  |  |                                       | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |                      |

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04612

## CERTIFICATE OF DEATH

04613

|  |  |  |  |  |   |
|--|--|--|--|--|---|
| 1. PLACE OF DEATH<br>o. COUNTY Anne Arundel MARYLAND   |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE Maryland b. COUNTY Calvert |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville   |  | c. LENGTH OF STAY IN lb<br>1mo. 11 days                                |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cherry Hill |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>Crownsville State Hospital   |  |  | d. STREET ADDRESS<br>Unknown   |  |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |   |
| 3. NAME OF DECEASED<br>(Type or print) 3-#34898  | First Ernest   | Middle   | Last Polk  | 4. DATE OF DEATH<br>Month 4  | Day 25 Year 1967                            |
| S. SEX Male  | 6. COLOR OR RACE Negro   | 7. MARRIED<br>WIDOWED <input type="checkbox"/>                         | NEVER MARRIED <input type="checkbox"/><br>DIVORCED <input type="checkbox"/>  | B. DATE OF BIRTH<br>1885   | 9. AGE (In years last birthday)<br>82? yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Retired   |  | 10b. KIND OF BUSINESS OR INDUSTRY -----                                |  | 11. BIRTHPLACE (County & State, or foreign country)<br>Maryland                              |   |
| 13. FATHER'S NAME<br>Asbury Polk   |  |  | 14. MOTHER'S MAIDEN NAME<br>Burke  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) No  | 16. SOCIAL SECURITY NO.<br>214-18-5723   | 17. INFORMANT<br>Nora  | Address<br>Hospital Records  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease<br>4221<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) General Arteriosclerosis<br>DUE TO<br>(c) |  |  |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>Diabetes Mellitus; Cachexia; Chronic Brain Syndrome  |  |  |  |  |   |
| 20a. MEDICAL CERTIFICATION<br>ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, NOTIFY MEDICAL EXAMINER)   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)<br>-----                |  |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. --- P.m. 19  | 20d. INJURY OCCURRED<br>While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) -----  | (County) -----   | (State) -----                               |
| 21. I certify that (I) (this hospital) attended the deceased from 3/14, 1967, to 4/25, 1967, that (I) (we) last saw the deceased alive on 4/25, 1967, and that death occurred at 1 PM, from causes and on the date stated above.   |  |  |  |  |   |
| 22a. SIGNATURE<br><i>Benard Benedict</i>   | M.D. ATTENDING PHYS. <input type="checkbox"/>  | MED. DIRECTOR <input type="checkbox"/>                                 | STAFF PHYS. <input checked="" type="checkbox"/>  | 22b. DATE SIGNED<br>4/25/67  |   |
| 22c. PHYSICIAN'S NAME (Type)<br>L. Benedict, M. D.   | 22d. ADDRESS<br>Crownsville State Hospital, Maryland   |  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>4-30-67   | 23b. DATE THEREOF<br>4-30-67   | 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS<br>Eastern Ch. Cem        | 23d. LOCATION (City or Town)<br>Lusby  | (County) -----   | (State) -----                               |
| 24. FUNERAL DIRECTOR<br>Linkney T. Sewell Prince Frederick, Md.  | ADDRESS  | 25a. REC'D BY REGISTRAR<br>DATE MAY 1 1967                             | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge  |  |   |

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04613

CERTIFICATE OF DEATH

04614

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |                                  |  |  |   |   |   |                   |                     |
|--|----------------------------------|--|--|---|---|---|-------------------|---------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><i>Anne Arundel</i>  |                                  | MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)<br>a. STATE<br><i>Maryland</i>      |   | b. COUNTY<br><i>Anne Arundel</i>  |                   |                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Annapolis</i>   |                                  | c. LENGTH OF STAY IN 1b<br><i>1 month</i>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Near Annapolis - Pendennis Ht.</i> |   | d. STREET ADDRESS<br><i>8 Brice Rd.</i>   |                   |                     |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><i>Anne Arundel General</i>  |                                  |  |  | d. STREET ADDRESS<br><i>8 Brice Rd.</i>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                   |                     |
| 3. NAME OF DECEASED (Type or print)<br><i>Margaret Selby Pritchard</i>   |                                  | First<br><i>Margaret</i>   | Middle<br><i>Selby</i>                   | Last<br><i>Pritchard</i>  | 4. DATE OF DEATH<br><i>April 9 1967</i> | Month<br><i>April</i>   | Doy<br><i>9</i>   | Year<br><i>1967</i> |
| S. SEX<br><i>Female</i>  | 6. COLOR OR RACE<br><i>White</i> | 7. MARRIED<br><input checked="" type="checkbox"/> NEVER MARRIED<br><input type="checkbox"/> WIDOWED<br><input type="checkbox"/> DIVORCED | B. DATE OF BIRTH<br><i>Aug. 10, 1919</i> | 9. AGE (In years lost birthday)<br><i>47 yrs.</i>   | IF UNDER 1 YEAR<br>Months<br><i>4</i>   | IF UNDER 24 HRS.<br>Days<br><i>0</i>  | Hours<br><i>0</i> | Min.<br><i>0</i>    |
| 100. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>Home</i>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><i>Washington, N.C.</i>  |   | 12. CITIZEN OF WHAT COUNTRY<br><i>USA</i>   |                   |                     |
| 13. FATHER'S NAME<br><i>Herman G. Selby</i>  |                                  | 14. MOTHER'S MAIDEN NAME<br><i>Kosalee Hill</i>  |  |   |   |   |                   |                     |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><i>No</i>   |                                  | 16. SOCIAL SECURITY NO.<br><i>—</i>  |  | 17. INFORMANT<br><i>William R. Pritchard</i>  |   | Address<br><i>#2</i>  |                   |                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><i>154X</i>   |                                  |  |  | <i>Carcinoma gluteosigmoid with<br/>Cerebral + pulmonary metastases</i>   |   | INTERVAL BETWEEN ONSET AND DEATH<br><i>3 mo</i>   |                   |                     |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br><i>—</i>   |                                  | (b)  | DUE TO                                   |   |   |   |                   |                     |
|  |                                  | (c)  | DUE TO                                   |   |   |   |                   |                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                                  |  |  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |                   |                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)   |  |   |   |   |                   |                     |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m.<br>p.m.<br><i>19</i>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>                                |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><i>116</i>                                      |   | 20f. (City or town) (County) (State)  |                   |                     |
| 21. I certify that (I) (this hospital) attended the deceased from <i>116</i> , 19 <i>67</i> , to <i>4/15</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>4/8</i> 19 <i>67</i> , and that death occurred at <i>7:58 PM</i> , from causes and on the date stated above. |                                  |  |  |   |   |   |                   |                     |
| 22a. SIGNATURE<br><i>Richard N. Peeler</i>   |                                  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>   |  | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |   | 22b. DATE SIGNED<br><i>4/10/67</i>  |                   |                     |
| 22c. PHYSICIAN'S NAME (Type)<br><i>RICHARD N. PEELER</i>   |                                  | 22d. ADDRESS<br><i>121 CATHEDRAL ST ANNAPOLIS MD</i>   |  |   |   |   |                   |                     |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Removal</i>  |                                  | 23b. DATE THEREOF<br><i>4/10/67</i>  |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br><i>—</i>  |   | 23d. LOCATION (City or Town) (County) (State)<br><i>Goldsboro N.C.</i>                            |                   |                     |
| 24. FUNERAL DIRECTOR<br><i>John H. Layla &amp; Sons Annapolis, Md.</i>   |                                  | ADDRESS  |  | 25a. REC'D BY REGISTRAR<br><i>APR 12 1967</i>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |                   |                     |

PIANO

1950-30-382910

1950-30-

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages and 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04614

## CERTIFICATE OF DEATH

04615

|   |                       |  |   |  |  |  |  |
|---|-----------------------|--|---|--|--|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY Anne Arundel<br>MARYLAND   |                       |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE Maryland<br>b. COUNTY Anne Arundel |  |  |  |
| b. CITY OR TOWN (If outside corporate limits,<br>Give RURAL and give nearest town)<br>Glen Burnie   |                       | c. LENGTH OF STAY IN lb  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Pasadena, Maryland                               |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>North Arundel Hospital  |                       |  |   | d. STREET ADDRESS<br>9 Gray Drive, Route 7,  |  |  |  |
| e. IS RESIDENCE<br>ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |                       |  |   |  |  |  |  |
| 3. NAME OF<br>DECEASED<br>(Type or print)   |                       | First<br>Norman  | W.  | Middle<br>Pursell  | Last   | 4. DATE<br>OF<br>DEATH   | Month<br>April 21, 1967<br>Day<br>19<br>Year |
| S. SEX<br>M   | 6. COLOR OR RACE<br>W | 7. MARRIED<br><input checked="" type="checkbox"/> NEVER MARRIED<br><input type="checkbox"/> WIDOWED<br><input type="checkbox"/> DIVORCED                       | B. DATE OF BIRTH<br>7-6-13                              |  | 9. AGE (In years<br>last birthday)<br>53 yrs.                          | IF UNDER 1 YEAR<br>Months<br>Days                                | IF UNDER 24 HRS.<br>Hours<br>Min.            |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br>Supervisor  |                       |  | 10b. KIND OF BUSINESS OR<br>INDUSTRY<br>United Airlines |  | 11. BIRTHPLACE (County & State, or foreign country)<br>Mansfield, Ohio |  | 12. CITIZEN OF WHAT<br>COUNTRY? U.S.A.       |
| 13. FATHER'S NAME<br>Edward Pursell   |                       |  |   | 14. MOTHER'S MAIDEN NAME<br>Fredia Wolf  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <input type="checkbox"/> If yes give war or dates of service)<br>No  |                       | 16. SOCIAL SECURITY NO.<br>458/28/9065   |   | 17. INFORMANT<br>Mrs. Margaret Pursell   |  | Address<br>Same as # 2   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> INTERVAL BETWEEN<br>ONSET AND DEATH <u>2 hours</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a).<br>stating the underlying cause (b) <u>Coronary Artery Disease</u> <u>1 1/2 yrs</u><br>DUE TO<br>last. (c) |                       |  |   |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                       |  |   |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                       | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m.<br>p.m. 19  |                       | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm,<br>factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)<br>67                       |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11/17</u> , 19 <u>65</u> , to <u>4/21</u> , 19 <u>67</u> , that (I) (we) last<br>saw the deceased alive on <u>3/21</u> 19 <u>67</u> , and that death occurred at <u>8:20 AM</u> , from causes and on the date stated above.  |                       |  |   |  |  |  |  |
| 22a. SIGNATURE<br><u>Samuel Morrison</u>  |                       | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>   |   | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  | 22b. DATE SIGNED<br>April 21, 1967                               |  |
| 22c. PHYSICIAN'S NAME (Type) <u>SAMUEL MORRISON</u>   |                       | 22d. ADDRESS<br>11 E. Chase St 21202   |   |  |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Cremation   |                       | 23b. DATE THEREOF<br>April 24, 67  |   | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Cleveland Cremation Co.  |  | 23d. LOCATION (City or Town) (County) (State)<br>Cleveland, Ohio |  |
| 24. FUNERAL DIRECTOR<br>R.V. SINGLETON,   |                       | ADDRESS<br>GLEN BURNIE, MD.  |   | 25a. REC'D BY REGISTRAR<br>DATE APR 24 1967  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>               |  |

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HEART TO JOHNSON

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and, it seems, will be here. I understand

the time.

It is a total waste.

Very truly yours

John Johnson

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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04615

## CERTIFICATE OF DEATH

06147

|   |                         |   |                                |   |  |   |  |           |
|---|-------------------------|---|--------------------------------|---|--|---|--|-----------|
| 1. PLACE OF DEATH<br>a. COUNTY ANNE ARUNDEL MARYLAND  |                         |   |                                | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE MARYLAND b. COUNTY ANNE ARUNDEL |  |   |  |           |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>FORT GEORGE G. MEADE  |                         | c. LENGTH OF STAY IN lb<br>DOA  |                                | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>FORT GEORGE G. MEADE                          |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |           |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>OLD LOGGING ROAD OFF REECE ROAD   |                         |   |                                | d. STREET ADDRESS<br>1931-D REECE ROAD  |  |   |  |           |
| 3. NAME OF<br>DECEASED<br>(Type or print)   |                         | First RUSSELL   | Middle WILLIAM                 | Last RADER  | 4. DATE<br>OF<br>DEATH April           | Month   | Day 20   | Year 1967 |
| S. SEX<br>MALE  | 6. COLOR OR RACE<br>CAU | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>6 NOV 1933 | 9. AGE (In years<br>last birthday)<br>33 yrs.   | IF UNDER 1 YEAR<br>Months              | IF UNDER 24 HRS.<br>Days  | Hours  | Min.      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Officer  |                         | 10b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Marine Corp   |                                | 11. BIRTHPLACE (County & State, or foreign country)<br>Pasco, Washington  |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA   |  |           |
| 13. FATHER'S NAME<br>William Ward Rader   |                         |   |                                | 14. MOTHER'S MAIDEN NAME<br>Thelma Supplee  |  |   |  |           |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br>Yes   |                         | 16. SOCIAL SECURITY NO.<br>14 Sep 51-Present 543-34-8289  |                                | 17. INFORMANT<br>Serviceman Personnal Record  |  | Address   |  |           |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carbon monoxide intoxication</u>  |                         |   |                                | INTERVAL BETWEEN<br>ONSET AND DEATH   |  |   |  |           |
| 973.1<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>(c)   |                         |   |                                |   |  |   |  |           |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                         |   |                                | 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                              |  |   |  |           |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, NOTIFY MEDICAL EXAMINER)   |                         | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)<br>Patient found in auto on Old Logging Rd off Reece Rd,       |                                |   | Ft Geo G. Meade,<br>Md.                |   |  |           |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m.<br>p.m. 19  |                         | 20d. INJURY OCCURRED 3<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |           |
| 21. I certify that <del>the deceased died in the deceased died in the</del> the deceased <del>from</del> WAS DOA <del>on</del> <del>to</del> <del>on</del> <del>20 Apr 1967</del><br><del>the deceased died in the</del> <del>xix</del> , and that death occurred at <del>11:35M</del> from causes and on the date stated above |                         |   |                                | 22b. DATE SIGNED<br>20 April 1967   |  |   |  |           |
| 22a. SIGNATURE<br><i>JAMES F. CLARK</i>   |                         |   |                                | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>  | MED. DIRECTOR <input type="checkbox"/> | STAFF PHYS. <input type="checkbox"/>  | 22b. DATE SIGNED<br>20 April 1967                  |           |
| 22c. PHYSICIAN'S NAME (Type) JAMES F. CLARK, CPT, MC  |                         |   |                                | 22d. ADDRESS<br>1st US Army Med Lab #1, FtGeoG.Meade, Md  |  |   |  |           |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL   |                         | 23b. DATE THEREOF<br>April 26, 1967   |                                | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Sunset Memorial Garden Cem., Sunnyside, Washington  |  | 23d. LOCATION (City or Town) (County) (State)   |  |           |
| 24. FUNERAL DIRECTOR<br>Harold S. Wade, Laurel, Maryland 20810  |                         |   |                                | ADDRESS   |  | 25a. REC'D BY REGISTRAR<br>DATE MAY 9 1967  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i> |           |

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DATE 10 JUN 1950

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OCIO ECONOMICO EN LA SOCIEDAD  
POLITICO-ECONOMICO

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04616

CERTIFICATE OF DEATH

04616

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>   |   | b. COUNTY<br><b>Anne Arundel</b>   |  |
| c. LENGTH OF STAY IN lb  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>                 |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Anne Arundel General Hospital</b>   |   | d. STREET ADDRESS<br><b>405 Giddings Ave.,</b>   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |  |  |
| 53 3. NAME OF DECEASED (Type or print)<br><b>Anna Louise RAVENSCROFT</b>   |   | 4. DATE OF DEATH<br><b>April 10 1967</b>   | Month Day Year   |
| S. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED<br><b>WIDOWED</b>   | 8. DATE OF BIRTH<br><b>Jan. 25, 1899</b>   |
| 9. AGE (In years lost birthday)<br><b>68 yrs.</b>  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOME</b> | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>HOME</b>   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>t.s.</b>  |   |  |  |
| 13. FATHER'S NAME<br><b>John Hartman</b>   | 14. MOTHER'S MAIDEN NAME<br><b>MARY Steattmeyer</b>   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   | 16. SOCIAL SECURITY NO.<br><b>17. INFORMANT</b>   | Address<br><b>HAROLD E. RAVENSCROFT #2</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)   |   |  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>592X</b> DUE TO <b>Malaria</b> INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b>   |   |  |  |
| Conditions, if any, which gave rise to immediate cause (a) (b) DUE TO <b>Ch. Nephritis</b> ?   |   |  |  |
| stating the underlying cause (c)   |   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)<br><b>Ch. Asthma myitis w/ anemia</b>   |   |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  |  |
| 20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                         |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m.<br>p.m. 19   |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>            | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State) |
| 21. I certify that (I) <b>(Physician)</b> attended the deceased from <b>19</b> , to <b>April 19 1967</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>April 19, 1967</b> , and that death occurred at <b>M</b> , from causes ond on the date stated above. |   |  |  |
| 22a. SIGNATURE<br><b>Maurice Klawans</b>   |   | 22b. DATE SIGNED<br><b>4/11/67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Maurice Klawans, MD.</b>  |   | 22d. ADDRESS<br><b>31 Southgate Ave., Annapolis, Md.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 23b. DATE THEREOF<br><b>4-12-67</b>   | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>St. Anne's</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Annapolis</b>  |
| 24. FUNERAL DIRECTOR<br><b>John M. Taylor Annapolis, Md.</b>   |   | 25a. REC'D BY REGISTRAR<br><b>APR 12 1967</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles George</b>  |
| ADDRESS  |   |  |  |



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

04617

**CERTIFICATE OF DEATH**

04617

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel MARYLAND</b>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b>                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>  |  | c. LENGTH OF STAY IN 1b<br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>     |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Anne Arundel General Hospital</b>  |  | d. STREET ADDRESS<br><b>119 Chester Ave.,</b>   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF<br>DECEASED<br>(Type or print)   | First<br><b>Earl</b>   | Middle<br><b>Yater</b>  | 4. DATE<br>OF<br>DEATH<br><b>April 14 1967</b>                                   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED<br><b>X</b> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Mar. 24, 1920</b>   |
| 9. AGE (In years<br>lost birthday)<br><b>47 yrs.</b>  | 10. IF UNDER 1 YEAR<br>Months<br><b>0</b>  | 11. IF UNDER 24 HRS.<br>DAYS<br><b>0</b>  | 12. IF UNDER 24 HRS.<br>Hours<br><b>0</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br><b>DRIVER USNA.</b>   | 10b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>LAUNDRY</b>   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>  |  |
| 13. FATHER'S NAME<br><b>CLIFTON E. RAWLINGS</b>   | 14. MOTHER'S MAIDEN NAME<br><b>BESSIE BALL</b>   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes or no unknown) <b>Yes</b>   | 16. SOCIAL SECURITY NO.<br><b>WWI</b>  | 17. INFORMANT<br><b>FLORENCE S. RAWLINGS #2</b>   | Address  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>4201</b><br>DUE TO<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. (b)<br>DUE TO<br>(c)<br>INTERVAL BETWEEN<br>ONSET AND DEATH<br><b>Weeks.</b> |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |   |  |
| 20a. MEDICAL CERTIFICATION<br>ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m.<br>p.m. <b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  | 20e. PLACE OF INJURY (Home, farm,<br>factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) <b>John M. Taylor</b> attended the deceased from <b>4/14</b> , 1966, to <b>Apr. 14</b> , 1967, that (I) <b>John M. Taylor</b> last saw the deceased alive on <b>Apr. 14</b> , 1967, and that death occurred at <b>M</b> , from causes and on the date stated above.  |  |   |  |
| 22a. SIGNATURE<br><b>General Observe</b>  | M.D. <b>3:30 AM</b><br><input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. | 22b. DATE SIGNED<br><b>4/14/67</b>  |  |
| 22c. PHYSICIAN'S<br>NAME (Type)<br><b>GORMAN CYPNELL</b>  | 22d. ADDRESS<br><b>121 Cathedral St., Annapolis, Md.</b>   |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>BURIAL</b>   | 23b. DATE THEREOF<br><b>4-17-1967</b>  | 23c. NAME OF CEMETERY OR CREMATORIUM<br><b>CEDAR BLUFF Cem.</b>   | 23d. LOCATION (City or Town)<br><b>Annapolis</b> (County) (State)<br><b>M.D.</b> |
| 24. FUNERAL DIRECTOR<br><b>JOHN M. TAYLOR SON ANNAPOULIS MD.</b>  | ADDRESS  | 25a. REC'D BY REGISTRAR<br><b>APR 17 1967</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                               |

22 May 1984 CULTIVATION OF PARMESAN CHEESE  
BY B. S. BAWA AND T. S. SHAH

MD 21-0781-A-11-12663 CESSNA 172N25CEW HARRISBURG PA 17103  
S/N 17252412663 21-0781-A-11-12663

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04618

CERTIFICATE OF DEATH

04618

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><u>Anne Arundel</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><u>Maryland</u> b. COUNTY<br><u>Anne Arundel</u>       |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Glen Burnie, Md.</u>  | c. LENGTH OF STAY IN lb<br><u>30 Yrs.</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Glen Burnie</u>  | d. STREET ADDRESS<br><u>P.O. Box 429</u>  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>North Arundel Hospital</u>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><u>Geraldine</u>   | First<br><u>F.</u>                        | Middle<br><u>Reilly</u>   | 4. DATE OF DEATH<br>April 8 19 67   |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u>          | 7. MARRIED<br><u>XX</u> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                        | 8. DATE OF BIRTH<br><u>11-22-96</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own Home</u>  | 9. AGE (In years last birthday)<br><u>70 yrs.</u>   |
| 13. FATHER'S NAME<br><u>Hugh Alexander</u>   |   | 14. MOTHER'S MAIDEN NAME<br><u>Unknown</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)   |   | 16. SOCIAL SECURITY NO.   | 17. INFORMANT<br><u>Wilfred Reilly, same as 2</u>   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (o)<br><u>434.2</u>   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 day</u>  |   |
| Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last.<br>(b)<br><u>Heart failure</u>  |   | DUE TO<br>(c)<br><u>Heart failure</u>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)   |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m.<br>p.m.<br><u>April 8 1967</u>   |   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>400 Cray Hwy n. w Glen Burnie, Md.</u> |
| 21. I certify that (I) (this hospital) attended the deceased from <u>April 8, 1967</u> , to <u>April 8, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 8, 1967</u> , and that death occurred at <u>1:00 PM</u> , from causes and on the date stated above. |   | 20f. (City or town) (County) (State)  |   |
| 22a. SIGNATURE<br><u>Robert Oabowin</u>  |   | M.D. ATTENDING PHYS.<br><input checked="" type="checkbox"/>   | MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>ROBERT OABOWIN MD</u>   |   | 22b. DATE SIGNED<br><u>Apr 18, 1967</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |   | 23b. DATE THEREOF<br><u>10 Apr. 67</u>  | 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS<br><u>Glen Haven Memorial</u>  |
| 24. FUNERAL DIRECTOR<br><u>Kirkley Funeral Home, Glen Burnie, Md.</u>  |   | 25a. REC'D BY REGISTRAR<br><u>APR 13 1967</u>   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |

6100

6100

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04613

CERTIFICATE OF DEATH

04619

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY<br><b>Anne Arundel</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE<br><b>Maryland</b> b. COUNTY<br><b>Baltimore City</b>        |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b>   |   | c. LENGTH OF STAY IN lb<br><b>7 days</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Crownsville State Hospital</b>  |   | d. STREET ADDRESS<br><b>6220 Brook Ave.</b>  |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>3-#35117 John</b>  |   | First<br><b>John</b>   | Middle<br><b></b>  |
| 4. DATE OF DEATH<br><b>Rizzo 4 12 1967</b>   | Month<br><b>4</b>   | Doy<br><b>12</b>   | Year<br><b>1967</b>  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED<br><b>XX</b> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                              | 8. DATE OF BIRTH<br><b>Sept. 13, 1897</b>  |
| 9. AGE (In years<br>last birthday)<br><b>69 yrs.</b>   | 10. IF UNDER 1 YEAR<br>Months<br><b>0</b>   | 11. IF UNDER 24 HRS.<br>Dys<br><b>0</b>  | 12. IF UNDER 24 HRS.<br>Hours<br><b>0</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br><b>Unemployed Shoemaker (Retired)</b>  |   | 10b. KIND OF BUSINESS OR<br>INDUSTRY   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Italy</b>  |   | 12. CITIZEN OF WHAT<br>COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Frank Rizzo</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Lucia Gudice</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   | 16. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br><b>No 219-18-9847</b> | 17. INFORMANT<br><b>Hospital Records</b>   | Address  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |   |  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>C.V.A - Possible Cerebral Hemorrhage</b> INTERVAL BETWEEN<br>ONSET AND DEATH<br><b>442X</b>   |   |  |  |
| Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last.<br>(b) <b>Hypertensive Cardiovascular Renal Disease</b>  |   |  |  |
| (c) <b>Arteriosclerosis</b>  |   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)   |   |  |  |
| <b>Urinary Retention &amp; Hypostatic Bruises</b>  |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)<br>-----  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. ----- 19<br>p.m. -----   |   | 20d. INJURY OCCURRED<br>White <input type="checkbox"/> Not White <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm,<br>factory, street, office bldg., etc.)<br>----- |
| 21. I certify that (I) (this hospital) attended the deceased from <b>4/5</b> , 19 <b>67</b> , to <b>4/12</b> , 19 <b>67</b> , that (I) (we) last<br>saw the deceased alive on <b>4/12</b> 19 <b>67</b> , and that death occurred at <b>3P.M.</b> , fram causes and an the date stated above. |   | 20f. (City or town) (County) (State)<br>-----  |  |
| 22. SIGNATURE<br><b>Lionel McHenry Mapp</b>  |   | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                           | 22b. DATE SIGNED<br><b>4/12/67</b>   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Lionel McHenry Mapp, M.D.</b>   |   | 22d. ADDRESS<br><b>Crownsville State Hospital, Maryland</b>  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>  |   | 23b. DATE THEREOF<br><b>4/17/67.</b>   | 23c. NAME OF CEMETERY OR CREMATORIUM<br><b>Holy Redeemer Cemetery</b>              |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>  |   | ADDRESS<br><b></b>   | 25a. RECEIVED BY REGISTRAR<br>DATE <b>APR 13 1967</b>                              |
|  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                 |

330

- 123 -

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04620

## CERTIFICATE OF DEATH

04620

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY Anne Arundel County MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE Maryland b. COUNTY Anne Arundel <i>B/G</i>  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie, Md</i>   | c. LENGTH OF STAY IN lb<br><i>33 hrs</i>  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bowie, Maryland</i>   | d. STREET ADDRESS <i>12400 XXX Stirrup Lane</i>                                |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>54 North Arundel Hospital</i>   |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print) <i>Mary</i>   | First <i>C.</i>   | Middle <i>Ruch</i>  | 4. DATE OF DEATH <i>April 10, 1967</i>   |
| 5. SEX <i>Female</i>  | 6. COLOR OR RACE <i>Cauc.</i>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <i>Nov. 21, 1877</i>  |
| 9. AGE (In years last birthday) <i>89 yrs.</i>  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i> |   | 11. BIRTHPLACE (County & State, or foreign country) <i>Philadelphia, Penn.</i> |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>  |   | 13. FATHER'S NAME <i>Charles Bohn</i>   |  |
| 14. MOTHER'S MAIDEN NAME <i>Unknown</i>   |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>   |  |
| 16. SOCIAL SECURITY NO. <i>213-54-8808</i>  |   | 17. INFORMANT <i>George E. Ruch, same as 2</i>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |   | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>4231</i><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <i>sclerotic Cardio Vascular Disease</i><br>DUE TO<br>(c) <i>Disease</i> |   | <i>Cerebral Hemorrhage -</i>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <i>19</i>   |   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)         |
| 20f. (City or town) <i>Philadelphia</i> (County) <i>Philadelphia</i> (State) <i>P.A.</i>  |   | 21. I certify that (I) (this hospital) attended the deceased from <i>Jan 1, 1962</i> to <i>April 10, 1967</i> , that (I) (we) last saw the deceased alive on <i>April 10, 1967</i> , and that death occurred on <i>Apr 10, 1967</i> , from causes and on the date stated above. |  |
| 22a. SIGNATURE <i>Felix Feibus</i>  |   | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  | 22b. DATE SIGNED <i>4/10/67</i>  |
| 22c. PHYSICIAN'S NAME (Type) <i>Felix G. Feibus</i>   |   | 22d. ADDRESS <i>1119 Columbia Rd. Philadelphia</i>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>   |   | 23b. DATE THEREOF <i>4/14/67</i>  | 23c. NAME OF CEMETERY OR CREMATORIAL <i>Greenmount</i>                         |
| 23d. LOCATION (City or Town) <i>Philadelphia, P.A.</i>  |   | (County) <i>Philadelphia</i> (State) <i>P.A.</i>  |  |
| 24. FUNERAL DIRECTOR <i>Kirkley Funeral Home, Glen Burnie, Md.</i>  |   | ADDRESS   | 25a. REC'D BY REGISTRAR <i>APR 12 1967</i>                                     |
|   |   |   | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>                                |

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**04621****CERTIFICATE OF DEATH****04621**

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY<br><b>Anne Arundel</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Anne Arundel</b>    |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>   |                                  | c. LENGTH OF STAY IN lb<br><b>2½ hrs.</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Anne Arundel General Hospital</b>   |                                  | d. STREET ADDRESS<br><b>400 Ash Circle</b>  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |  |
| 3. NAME OF DECEASED (Type or print) <b>INFANT William C. SCHATZ</b>  |                                  | 4. DATE OF DEATH<br><b>April 13, 1967</b>   | Month Day Year<br><b>April 13 19 67</b>  |
| S. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>April 13, 1967</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Newborn</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Anne Arundel, Maryland</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |
| 13. FATHER'S NAME<br><b>J. Lawrence Schatz</b>   |                                  | 14. MOTHER'S MARRIED NAME<br><b>J. Lawrence Schatz wife Alice</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>—</b>   |  |
| 17. INFORMANT<br><b>J. Lawrence Schatz</b>   |                                  | Address<br><b>—</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypoxia, intrapartum</b><br>DUE TO <b>7610</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Obstructio placenta</b><br>DUE TO <b>—</b><br>last (c) <b>Premature onset of labor</b> |                                  |   |  |
| INTERVAL BETWEEN ONSET AND DEATH<br><b>—</b>   |                                  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                                  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. <b>p.m.</b> 19   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>—</b> |
| 20f. (City or town) <b>—</b> (County) <b>—</b> (State) <b>—</b>  |                                  |   |  |
| 21. I certify that (I) <b>(Robert A. Riley)</b> attended the deceased from <b>Apr. 13, 1967</b> , to <b>Apr. 13, 1967</b> , that (I) <b>(he)</b> last saw the deceased alive on <b>Apr. 13, 1967</b> , and that death occurred at <b>M</b> , from causes and on the date stated above.   |                                  |   |  |
| 22a. SIGNATURE<br><b>Robert A. Riley Jr.</b>   |                                  | 3:45 AM<br>M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>             | 22b. DATE SIGNED<br><b>4/14/67</b>   |
| 22c. PHYSICIAN'S NAME (Type) <b>ROBERT A. RILEY JR</b>   |                                  | 22d. ADDRESS<br><b>95 CATHEDRAL ST., ANNAPOLIS, MD.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>4/14/67</b>   | 23c. NAME OF CEMETERY OR CREMATORIUM<br><b>New Cathedral Cemetery</b>              |
| 24. FUNERAL DIRECTOR<br><b>Robert J. Barranco, Sevna Ph.D.</b>   |                                  | ADDRESS<br><b>ROBERT S. BARRANCO #7-237268</b>  | 25a. REC'D BY REGISTRAR<br><b>APR 17 1967</b>                                      |
|  |                                  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                 |

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# MARYLAND STATE DEPARTMENT OF HEALTH

**Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

04622

## **CERTIFICATE OF DEATH**

04622

|   |                                       |   |  |   |  |
|---|---------------------------------------|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY Anne Arundel MARYLAND  |                                       |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE Maryland b. COUNTY                 |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville  | c. LENGTH OF STAY IN lb 11mos. 21das. | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore  |  |   | 30-4   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital   |                                       |   | d. STREET ADDRESS 615 S. Savage Street   |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) #32113  | First Anna                            | Middle M.   | Last Scheuring   | 4. DATE OF DEATH Month 4                                    | Doy 21 Year 67   |
| S. SEX Female   | 6. COLOR OR RACE White                | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH 1/4/94  | 9. AGE (In years lost birthday) 73 yrs.                     | IF UNDER 1 YEAR Months 0 Doy 0 Hours 0 Min. 0  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired   |                                       | 10b. KIND OF BUSINESS OR INDUSTRY -----   | 11. BIRTHPLACE (County & State, or foreign country) Germany  |   | 12. CITIZEN OF WHAT COUNTRY? USA   |
| 13. FATHER'S NAME Unknown   |                                       |   | 14. MOTHER'S MAIDEN NAME Unknown   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Lirk  |                                       | 16. SOCIAL SECURITY NO. 052-01-3442   | 17. INFORMANT Address Hospital Records   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Uremia<br>442X<br>DUE TO<br>(b) Arteriosclerotic Hypertensive Cardiovascular<br>XXK XOX Renal Disease.<br>(c) |                                       |   | INTERVAL BETWEEN ONSET AND DEATH   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>Hypostatic Pneumonia  |                                       |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                    |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                                       | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)<br>-----   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. 79   |                                       | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town)   | (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from 5/17/1966 to 4/21/1967, that (I) (we) last saw the deceased alive on 4/21/1967, and that death occurred at 2515 M, from causes and on the date stated above.                |                                       |   |  |   |  |
| 22a. SIGNATURE Lionel McHenry Mapp.   |                                       |   | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | 22b. DATE SIGNED 4/21/67.                                   |  |
| 22c. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M.D.  |                                       |   | 22d. ADDRESS Crownsville State Hospital, Md.   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial  |                                       | 23b. DATE THEREOF 4/24/67   | 23c. NAME OF CEMETERY OR CREMATORIAL Sacred Heart Cem.   | 23d. LOCATION (City or Town) Baltimore (County) Md. (State) |  |
| 24. FUNERAL DIRECTOR Connally F.H.  |                                       |   | ADDRESS 300 More   | 25a. REC'D BY REGISTRAR APR 25 1967                         | 25b. REGISTRAR'S SIGNATURE Charles Judge   |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove garban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

04623

**CERTIFICATE OF DEATH**

04623

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b>  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>   |  | c. LENGTH OF STAY IN 1b<br><b>1 day</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Anne Arundel General Hospital</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED<br>(Type or print)   | First<br><b>Fred</b>   | Middle<br><b>erick</b>  | Last<br><b>Herman</b>  |
| 4. DATE OF DEATH   | Month<br><b>April</b>  | Day<br><b>2</b>   | Year<br><b>19 67</b>   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>July 16, 1916</b>                                 |
| 9. AGE (In years lost birthday)<br><b>50 yrs.</b>  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Welder</b>  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                              |
| 13. FATHER'S NAME<br><b>Conard F. Schulze</b>  | 14. MOTHER'S MAIDEN NAME<br><b>Gertrude L. Smith</b>   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  | 16. SOCIAL SECURITY NO.<br><b>214-01-9143</b>  | 17. INFORMANT<br><b>Anna M. Schulze - Wife</b>  | Address  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>154X</b> DUE TO <b>Ischaemia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Occlusion of arteries</b><br>DUE TO <b>Causation of sepsis</b> (c) |  |   |  |
| INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |   |  |
| 20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m.<br>p.m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>White <input type="checkbox"/> Not White <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                     |
| 21. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from _____, 19 _____, to April 2, 19 67, that (I) <input checked="" type="checkbox"/> last saw the deceased alive on April 2, 19 67, and that death occurred at 3:33 PM, from causes and on the date stated above.  |  |   |  |
| 22a. SIGNATURE<br><i>Jesse L. Wilkins</i>  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                           | 22b. DATE SIGNED<br><b>4-3-67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Jesse L. Wilkins, M.D.</b>  | 22d. ADDRESS<br><b>98 Cathedral St., Annapolis, Md.</b>  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>4/6/67</b>   | 23c. NAME OF CEMETERY OR CREMATORIUM<br><b>Glen Haven Memorial Pk.</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Glen Burnie, Md.</b> |
| 24. FUNERAL DIRECTOR<br><i>Robert Pitler</i>   | ADDRESS<br><b>Singleton Funeral Home/Glen Burnie, Maryland</b>   | 25a. REC'D BY REGISTRAR<br><b>APR 5 1967</b>  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                       |

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Figure 10. A schematic diagram showing the relationship between the three main components of the model: the population dynamics (left), the disease transmission (middle), and the control measures (right).

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.M  
104624

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

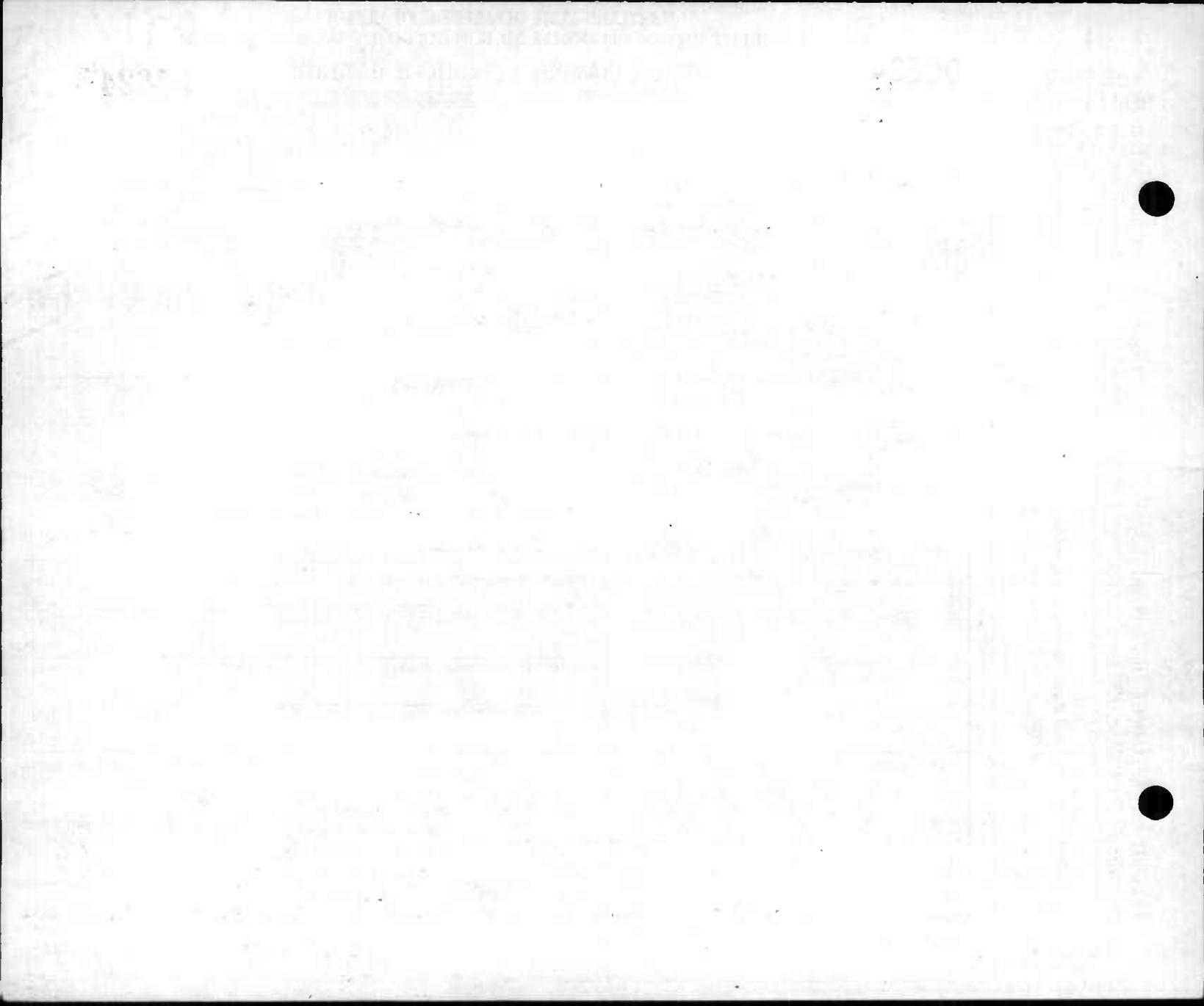
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

04624

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04624

|  |                              |   |   |  |  |  |                                       |                     |
|--|------------------------------|---|---|--|--|--|---------------------------------------|---------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><i>A.A. Co.</i>  |                              | MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><i>MARYland</i> |  | b. COUNTY<br><i>AACo.</i>  |                                       |                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>104624 Glen Burnie</i>  |                              | c. LENGTH OF STAY IN 1b<br><i>GLEN BURNIE</i>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Pesa Linda</i>                |  | d. STREET ADDRESS<br><i>263 Mallard Drive</i>  |                                       |                     |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><i>D.O.A - NORTH ARUNDEL Hosp.</i>   |                              |   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |  |  |                                       |                     |
| 3. NAME OF<br>DECEASED<br>(Type or print)<br><i>Anna</i>   |                              | First   | Middle  | Last   | 4. DATE<br>OF<br>DEATH<br><i>Scott</i>               | Month<br><i>4</i>  | Day<br><i>2</i>                       | Year<br><i>1967</i> |
| S. SEX<br><i>F</i>   | 6. COLOR OR RACE<br><i>W</i> | 7. MARRIED<br>WIDOWED<br><input type="checkbox"/>   | NEVER MARRIED<br>DIVORCED<br><input type="checkbox"/> | 8. DATE OF BIRTH<br><i>4-7-1905</i>  | 9. AGE (In years<br>lost birthday)<br><i>61 yrs.</i> | IF UNDER 1 YEAR<br>Months<br><i>0</i>  | IF UNDER 24 HRS.<br>Hours<br><i>0</i> |                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                              | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (State or foreign country)  |  | 12. CITIZEN OF WHAT COUNTRY?   |                                       |                     |
| 13. FATHER'S NAME  |                              | 14. MOTHER'S MAIDEN NAME  |   |  |  |  |                                       |                     |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)   |                              | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT  |  | Address  |                                       |                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><i>260X</i><br>Conditions, if any, which gave rise to immediate cause (a).<br>stating the underlying cause lost.<br>(b)<br>(c)   |                              | DUE TO<br><i>Cardiovascular Disease</i>   |   | DUE TO<br><i>Arterial Nephritis</i>  |  | INTERVAL BETWEEN<br>ONSET AND DEATH<br><i>Booster</i>  |                                       |                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                              |   |   |  |  |  |                                       |                     |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                       |                     |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m.<br>p.m.<br><i>19</i>   |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |                                       |                     |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                              |   |   |  |  |  |                                       |                     |
| ACTUAL<br>SIGNATURE<br><i>E. Linhardt</i>  |                              | EXAMINER'S<br>NAME (Type)<br><i>E. Linhardt</i>   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>M.D.  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county)<br><i>Johns Hopkins School of Medicine</i> |                                       |                     |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><i>X Removal</i>   |                              | 23b. DATE THEREOF<br><i>4/3/67</i>  |   | 23c. NAME OF CEMETERY OR CREMATORIALy<br><i>Johns Hopkins School of</i>  |  | 23d. LOCATION (City or Town) (County) (State)<br><i>709 N. Wolfe St, Baltimore</i>   |                                       |                     |
| 24. FUNERAL DIRECTOR   |                              | ADDRESS   |   | 25a. REC'D BY REGISTRAR<br>DATE<br><i>APR 4 1967</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |                                       |                     |



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04625

CERTIFICATE OF DEATH

04625

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><i>Anne Arundel Co., Maryland</i>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><i>MARYLAND</i>   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |  | c. LENGTH OF STAY IN 1b<br><i>Bowie 20715 16-2</i>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><i>ANNAPOLIS CONV. NURSING HOME</i>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><i>ISABEL M. SCOTT</i>  |  | First  | Middle  |
| 4. DATE OF DEATH<br><i>4 19 1880</i>  | Month<br><i>4</i>                                    | Doy<br><i>5</i>  | Year<br><i>1967</i>   |
| 5. SEX<br><i>F</i>  | 6. COLOR OR RACE<br><i>W</i>                         | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><i>4-19-1880</i>  |
| 9. AGE (In years lost birthday)<br><i>89 yrs.</i>   | 10. KIND OF BUSINESS OR INDUSTRY<br><i>HOUSEWIFE</i> | 11. BIRTHPLACE (County & State, or foreign country)<br><i>VIRGINIA</i>   | 12. CITIZEN OF WHAT COUNTRY?<br><i>US.</i>  |
| 13. FATHER'S NAME<br><i>EDWARD C. MARSHALL</i>  |  | 14. MOTHER'S MAIDEN NAME<br><i>BELLE RAINES</i>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><i>No</i>   |  | 16. SOCIAL SECURITY NO.<br><i>234-07-72123</i>   | 17. INFORMANT<br><i>R. WUFFELMAN SEC.</i>   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Pneumonia and U.R.I.</i> INTERVAL BETWEEN<br>ONSET AND DEATH <i>3 days</i><br>492X related DUE TO<br>Conditions, if any, which gave rise to immediate cause (a).<br>(b) <i>Severe cachexia, malnourishment, dehydration, 6 mos.</i><br>stating the underlying cause<br>(c) <i>Refusal to eat</i> 1 year.<br>DUE TO<br>lost. |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><i>ASCVD; chron. recurrent CHF; Senility; chronic brain syndrome</i>  |  |  |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |   |
| 20. MEDICAL CERTIFICATION<br>ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m.<br>p.m. 19  |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><i>None</i> |
| 21. I certify that (I) (this hospital) attended the deceased from <i>11-28 1966</i> , to <i>4-5 1967</i> that (I) (we) last saw the deceased alive on <i>4-3 1967</i> , and that death occurred at <i>5:50 AM</i> , from causes and on the date stated above.   |  | 22b. DATE SIGNED<br><i>4-5-67</i>  |   |
| 22c. SIGNATURE<br><i>PETER F. VERKOUW</i>   |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                           | 22d. ADDRESS<br><i>1407 Forest Drive Annapolis, Md</i>                                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |  | 23b. DATE THEREOF<br><i>April 7, 1967</i>  | 23c. NAME OF CEMETERY OR CREMATORIAL<br><i>Leeds Episcopal Church Cemetery, Hume</i>  |
| 24. FUNERAL DIRECTOR<br><i>Frederick E. Hopping</i>   |  | ADDRESS<br><i>HOPPING FUNERAL HOME</i>   | 25a. DATE BY REGISTRAR<br><i>APR 7 1967</i>   |
|   |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                                    |

OSANO

RS340

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04626

## CERTIFICATE OF DEATH

04626

|  |                        |  |   |   |  |  |
|--|------------------------|--|---|---|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY ANNE ARUNDEL MARYLAND   |                        |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE MARYLAND b. COUNTY ANNE ARUNDEL |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROSEDALE Glen Burnie DOA  |                        | c. LENGTH OF STAY IN lb  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital  |                        |  | d. STREET ADDRESS ROUTE 7, BOX 330-A, PASADENA  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) WILLIAM  |                        | First T.   | Middle  | Last SCOTT  | 4. DATE OF DEATH APRIL 21, 1967                                    | Month Doy Year   |
| 5. SEX MALE  | 6. COLOR OR RACE WHITE | 7. MARRIED WIDOWED   | NEVER MARRIED DIVORCED  | 8. DATE OF BIRTH 24 Aug. 1872   | 9. AGE (In years last birthday) 94 yrs.                            | IF UNDER 1 YEAR Months Days Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter  |                        | 10b. KIND OF BUSINESS OR INDUSTRY Retired  |   | 11. BIRTHPLACE (County & State, or foreign country) AA Co., Md.                           |  | 12. CITIZEN OF WHAT COUNTRY? USA   |
| 13. FATHER'S NAME John Scott   |                        |  | 14. MOTHER'S MAIDEN NAME Unk.   |   |  | Address  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No   |                        | 16. SOCIAL SECURITY NO. 218-18-3753A   |   | 17. INFORMANT Arthur W. Scott, Sr. same as 2  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Acute myocardial infarction<br>2600X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) coronary arteriosclerotic heart disease<br>DUE TO<br>(c) diabetes mellitus |                        |  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br>1 hour<br>1 year<br>2 years                                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>None   |                        |  |   |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                        | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. 19  |                        | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                    |  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Apr. 1, 1967</u> to <u>Apr. 21, 1967</u> , that (I) (we) last saw the deceased alive on <u>Apr. 15, 1967</u> , and that death occurred at <u>SP</u> M, from causes and on the date stated above.  |                        |  |   |   |  |  |
| 22a. SIGNATURE <u>Randall McLaughlin</u>   |                        | M.D.   | ATTENDING PHYS.   | MED. DIRECTOR <input checked="" type="checkbox"/>   | STAFF PHYS. <input type="checkbox"/>                               | 22b. DATE SIGNED 23 Apr. 67  |
| 22c. PHYSICIAN'S NAME (Type) Randall McLaughlin, M. D.   |                        | 22d. ADDRESS 3708 Mountain Road, Pasadena, Md.   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial   |                        | 23b. DATE THEREOF 24 April 67  | 23c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery  |   | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. 21225 |  |
| 24. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.  |                        | ADDRESS  |   | 25a. REC'D BY REGISTRAR   | 25b. REGISTRAR'S SIGNATURE Charles Judge                           |  |
|  |                        |  |   | DATE APR 25 1967  |  |  |

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1 M

04627

## CERTIFICATE OF DEATH

Items 1a &amp; 2a Telephone call Donaldson F.H. 4/24/67 rec 04627

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |   |  |   |  |   |  |  |  |                        |  |   |  |   |  |
|--|--|---|--|---|--|---|--|--|--|------------------------|--|---|--|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY   |  | Anne Arundel<br>Hobbsville  |  | MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE |  | Maryland                                     |  | b. COUNTY              |  | Anne Arundel  |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |  |   |  | c. LENGTH OF STAY IN 1b   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)                  |  | d. STREET ADDRESS                            |  |                        |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)   |  | Jessup  |  |   |  | d. STREET ADDRESS   |  | Jessup                                       |  |                        |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 3. NAME OF DECEASED (Type or print)  |  | First Robert Franklin Scruggs   |  | Middle  |  | Lost  |  | 4. DATE OF DEATH                             |  | Month April            |  | Day 7   |  | Year 1967   |  |
| 5. SEX   |  | 6. COLOR OR RACE W  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH Sept 12 1895   |  | 9. AGE (In years lost birthday) 71 yrs.      |  | IF UNDER 1 YEAR Months |  | IF UNDER 24 HRS Days  |  | Hours   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 10b. KIND OF BUSINESS OR INDUSTRY B & O Railroad  |  | 11. BIRTHPLACE (County & State, or foreign country) Virginia  |  | 12. CITIZEN OF WHAT COUNTRY? USA  |  |  |  |                        |  |   |  |   |  |
| 13. FATHER'S NAME Wm. Landau Scruggs   |  | 14. MOTHER'S MAIDEN NAME Josephine Thacker  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? no  |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT George W Scruggs, Arlington Va |  | Address                |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 177X<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a).<br>stating the underlying cause lost. |  | (b) DUE TO  |  | Carcinoma, Prostate<br>& Generalized Metastasis.  |  | INTERVAL BETWEEN ONSET AND DEATH ?           |  |                        |  |   |  |   |  |
| (c) DUE TO   |  |   |  |   |  |   |  |  |  |                        |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |   |  |   |  |   |  |  |  |                        |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |   |  |  |  |                        |  |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m.<br>p.m. 19   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/>          |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |  |  |                        |  |   |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from 1-1967, to 4-7-1967, that (H) (we) last saw the deceased alive on 4-7-1967, and that death occurred at 1:00 A.M. from causes and on the date stated above. |  |   |  |   |  |   |  |  |  |                        |  |   |  |   |  |
| 22a. SIGNATURE Rotando V. Goco   |  | M.D. ATTENDING PHYS.  |  | MED. DIRECTOR <input checked="" type="checkbox"/>   |  | STAFF PHYS. <input type="checkbox"/>  |  | 22b. DATE SIGNED 4-10-67                     |  |                        |  |   |  |   |  |
| 22c. PHYSICIAN'S NAME (Type) Rotando V. Goco, M.D.   |  | 22d. ADDRESS 704 Norman Ave   |  |   |  |   |  |  |  |                        |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial   |  | 23b. DATE THEREOF 4-10-67   |  | 23c. NAME OF CEMETERY OR CREMATORIAL Meadannridge Mem. Cemetery Md.   |  | 23d. LOCATION (City or Town) (County) (State)   |  |  |  |                        |  |   |  |   |  |
| 24. FUNERAL DIRECTOR De Witt Lannedian Laurel Md.  |  | ADDRESS   |  | 25a. RECEIVED BY REGISTRAR APR 14 1967  |  | 25b. REGISTRAR'S SIGNATURE Judge  |  |  |  |                        |  |   |  |   |  |
| VR A15 (4)<br>20 M 1/66  |  |   |  |   |  |   |  |  |  |                        |  |   |  |   |  |

43290

43290

Item 20b Film 388 5-1-6 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04628

Item #9 Film #G388 5/3/67

CERTIFICATE OF DEATH

04628

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>ANNE ARUNDEL</b>  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b>                     |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FT GEO G MEADE</b>  |   | c. LENGTH OF STAY IN 1b<br><b>DOA</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>KIMBROUGH ARMY HOSPITAL</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>GUADALUPA</b>   |   | First<br><b>GUADALUPA</b>  | Middle<br><b>DOLORES</b>   |
| 4. DATE OF DEATH<br><b>APRIL 23 1967</b>   | Month<br><b>APRIL</b>                     | Doy<br><b>23</b>   | Year<br><b>1967</b>  |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>CAU</b>            | 7. MARRIED<br><input checked="" type="checkbox"/> NEVER MARRIED<br><input type="checkbox"/> WIDOWED<br><input type="checkbox"/> DIVORCED | 8. DATE OF BIRTH<br><b>19 DEC 1938</b>   |
| 9. AGE (In years lost birthday)<br><b>28 yrs.</b>  | 10. IF UNDER 1 YEAR<br>Months<br><b>0</b> | 11. IF UNDER 24 HRS.<br>Days<br><b>0</b>   | 12. IF UNDER 24 HRS.<br>Hours<br><b>0</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Serviceman</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Army</b>  |  |
| 13. FATHER'S NAME<br><b>Antonio Serna</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Virginia Rioias</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>Yes</b>  |   | 16. SOCIAL SECURITY NO.<br><b>5Sep56-Present 453-60-1406</b>   | 17. INFORMANT<br><b>Military Personnel Records</b>                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |   |  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>976X Gun Shot Wound Head</b>   |   |  |  |
| DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)<br>DUE TO<br>(c)  |   |  |  |
| 19. INTERVAL BETWEEN ONSET AND DEATH   |   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |   |  |  |
| 20. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)<br><b>Suicide</b>                           |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. <b>23 Apr 1967</b>   |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>                     | 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)<br><b>Home</b>  |
| 20f. (City or town)<br><b>FtGeoMeade, Md</b>   |   | (County) <b>Anne Arundel</b>   |  |
| (State) <b>Md.</b>   |   |  |  |
| 21. I certify that <b>FRANK P. URSO</b> attended the deceased <b>X</b> WAS DOA <b>X</b> , t <sup>a</sup> <b>23 Apr</b> , 1967 <b>X</b> , and that death occurred at <b>8:55 M</b> , from causes and on the date stated above.<br><b>X</b> saw the deceased alive on <b>X</b> |   |  |  |
| 22a. SIGNATURE<br><b>Frank P. Urso CPT, MC</b>   |   |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>FRANK P. URSO, CPT, MC</b>  |   | ATTENDING PHYS. <input checked="" type="checkbox"/>  | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |
| 22b. DATE SIGNED<br><b>23 April 1967</b>   |   |  |  |
| 23a. BURIAL, CREMATION,<br>BURTAZ (Specify)  |   | 23b. DATE THEREOF<br><b>Apr. 28, 1967</b>  | 23c. NAME OF CEMETERY OR CREMATORIUM<br><b>LAREDO CATHOLIC CEMETERY</b>                |
| 23d. LOCATION (City or Town)<br><b>LAREDO, TEXAS</b>   |   | (County) <b>TEXAS</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>Harold S. Walk, Laurel, Md.</b>   |   | ADDRESS  | 25a. REC'D BY REGISTRAR<br><b>APR 27 1967</b>  |
|  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Juge</b>  |  |

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04623

## CERTIFICATE OF DEATH

04629

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><i>Glen Burnie</i>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><i>Md.</i>   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><i>Glen Burnie</i>   |  | b. COUNTY<br><i>Annapolis AA</i>  |  |
| c. LENGTH OF STAY IN 1b<br><i>1 week</i>   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><i>Annapolis</i>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><i>Walter Mann 7365 Annapolis Rd</i>   |  | d. STREET ADDRESS<br><i>535 Carroll Drive</i>   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><i>Edward Simms</i>  |  | 4. DATE OF DEATH<br>Last<br><i>Simms</i> Month<br><i>7</i> Day<br><i>3</i> Year<br><i>1967</i>  |  |
| 5. SEX<br><i>Male</i>  |  | 6. COLOR OR RACE<br>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Laborer</i>  |  | 9. AGE (In years last birthday) IF UNDER 1 YEAR<br>B. DATE OF BIRTH<br><i>7-26-1905</i> 62 yrs.<br>Months Days Hours Min.   |  |
| 10a. KIND OF BUSINESS OR INDUSTRY<br><i>Navy Yard</i>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><i>Annapolis Md United States</i>  |  |
| 13. FATHER'S NAME<br><i>John Simms</i>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>Mary - Unknown</i>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) If yes, give rank and dates of service<br><i>No</i>   |  | 16. SOCIAL SECURITY NO. 17. INFORMANT<br><i>319-03-4097 Claudelle S. Simms Anna M. Mc</i>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><i>Coronary Occlusion</i>  |  | Address<br><i>Se. Mrs. Claudelle S. Simms Anna M. Mc</i>  |  |
| DUE TO<br>Conditions, if any, which<br>gave rise to immediate cause<br>(a), stating the underlying<br>cause last.<br><i>4201</i>   |  | INTERVAL BETWEEN<br>ONSET AND DEATH<br><i>Se. Mrs. Claudelle S. Simms Anna M. Mc</i>  |  |
| {<br>} DUE TO<br>(b)<br><i>Cerebral Hemorrhage</i>   |  | Se. Mrs.<br><i>Unknown</i>  |  |
| {<br>} DUE TO<br>(c)<br><i>C. V. A.</i>  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OP. CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br><i>19</i>  |  | 20d. INJURY OCCURRED<br>Whila <input type="checkbox"/> Not Whila <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town)<br>(County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <i>March 31</i> , 1967, to <i>Apr. 3</i> , 1967, that (I) (we) last saw the deceased alive on <i>Mar. 31</i> , 1967, and that death occurred at <i>12 PM</i> , from the causes and on the date stated above. |  | 22b. DATE SIGNED<br><i>22b. DATE SIGNED</i>   |  |
| 22a. SIGNATURE<br><i>Richard H. Hunt</i>   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><i>Richard H. Hunt</i>   |  | 22d. ADDRESS<br><i>167 Cherry Lane, Glen Burnie, Md.</i>  |  |
| 23a. BURIAL, CREMATION, REMOVAL. (Specify)<br><i>Burial</i>  |  | 23b. DATE THEREOF<br><i>4-7-1967</i>  |  |
| 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS<br><i>Pine Lawn</i>   |  | 23d. LOCATION (City, town or county)<br><i>Annapolis Md.</i>  |  |
| 24 FUNERAL DIRECTOR'S SIGNATURE<br><i>William Keast Jr.</i>  |  | 25a. REC'D BY REGISTRAR<br>DATE APR 5 1967  |  |
| ADDRESS<br><i>108 W Washington St Annapolis MD</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04630

CERTIFICATE OF DEATH

04630

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY<br><br>Anne Arundel MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE Maryland b. COUNTY Anne Arundel   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><br>Annapolis  |  | c. LENGTH OF STAY IN lb<br>10 days  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><br>Anne Arundel General Hospital  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED<br>(Type or print)   | First<br>George                            | Middle<br>Washington  | Last<br>SIMMS   |
| 4. DATE OF DEATH<br>Month April<br>Doy 19<br>Year 1967   | 5. SEX Male                                | 6. COLOR OR RACE Negro  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |
| 8. B. DATE OF BIRTH<br>March 20, 1902  | 9. AGE (In years last birthday) yrs.<br>65 | 10. B. DATE OF BIRTH<br>March 20, 1902  | 11. BIRTHPLACE (County & State, or foreign country)<br>Maryland   |
| 12. CITIZEN OF WHAT COUNTRY?<br>U.S.   | 13. FATHER'S NAME<br>William S. Simms      | 14. MOTHER'S MAIDEN NAME<br>Charlotte Wells   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) If yes give war or dates of service<br>16. SOCIAL SECURITY NO.<br>214-05-2478          |
| 16. INFORMANT<br>Address<br>Mary Mathews 181 Pleasant St.  | 17. DUE TO<br>Carcinoma of Lung            | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (o)<br>163X<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b)<br>DUE TO<br>(c) | 19. INTERVAL BETWEEN ONSET AND DEATH<br>2 mos.  |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. 19  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State)  |
| 21. I certify that (I) (check) attended the deceased from <u>1-14-67</u> , 19 <u>67</u> , to <u>Apr. 19</u> , 19 <u>67</u> that (I) (check) last saw the deceased alive on <u>Apr. 19</u> 19 <u>67</u> , and that death occurred at _____ M, fram causes and on the date stated above. |  |   |   |
| 22a. SIGNATURE<br><i>A.T. Allen</i>  |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  | 22b. DATE SIGNED<br>8:40 PM <u>4-20-67</u>  |
| 22c. PHYSICIAN'S NAME (Type)<br>A. T. Allen, M.D.  |  | 22d. ADDRESS<br>62 Cathedral St., Annapolis, Md.  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial 4-23-67  | 23b. DATE THEREOF<br>Apr. 23, 1967         | 23c. NAME OF CEMETERY OR Crematory<br>Hope Chapel   | 23d. LOCATION (City or Town) (County) (State)<br>Elizabethtown, NC  |
| 24. FUNERAL DIRECTOR<br>William Reeset # Annap. Md.  | ADDRESS                                    | 25a. REC'D BY REGISTRAR<br>APR 21 1967  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and/or any event, within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04631

## CERTIFICATE OF DEATH

04631

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |                                 |   |  |   |  |
|---|---------------------------------|---|--|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY Anne Arundel MARYLAND  |                                 | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE Maryland b. COUNTY Charles ✓                              |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville  | c. LENGTH OF STAY IN lb 17 Days | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hughesville  | d. STREET ADDRESS Route #1, Box 196                                    |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital   |                                 | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| 3. NAME OF DECEASED (Type or print) Helen Marie Simon   | First                           | Middle  | Last   |   |  |
| 4. DATE OF DEATH 4 16 1967  | Month                           | Day   | Year   |   |  |
| 5. SEX F  | 6. COLOR OR RACE W              | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-28-92  | 9. AGE (In years last birthday) 74 yrs.                             | IF UNDER 1 YEAR Months Dots Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife   |                                 | 10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC  |  | 11. BIRTHPLACE (County & State, or foreign country) ILLINOIS        |  |
| 13. FATHER'S NAME Ernest Goelling   |                                 | 14. MOTHER'S MAIDEN NAME Anna   |  | 12. CITIZEN OF WHAT COUNTRY? U.S.A.                                 |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No  |                                 | 16. SOCIAL SECURITY NO. UNKNOWN   |  | 17. INFORMANT ARTHUR GOELLING, HUGHESVILLE, MD Address RT 1 BOX 196 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Chronic Pulmonary Disease<br>5271 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) Pulmonary Emphysema<br>(c) Pneumonia |                                 |   |  |   |  |
| INTERVAL BETWEEN ONSET AND DEATH  |                                 |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)<br>GI Malignancy & Inanition   |                                 |   |  |   |  |
| 20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                 | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. 19   |                                 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from 3-30, 1962, to 4-16, 1962, that (I) (we) lost<br>sow the deceased alive on 4-16 1962, and that death occurred at 10:02 AM, from causes and on the date stated above.  |                                 |   |  |   |  |
| 22a. SIGNATURE Alvin M. Brown, M.D.   |                                 | M.D. ATTENDING PHYS. <input type="checkbox"/>   | MED. DIRECTOR <input type="checkbox"/>                                 | STAFF PHYS. <input checked="" type="checkbox"/>                     | 22b. DATE SIGNED 4-16-67               |
| 22c. PHYSICIAN'S NAME (Type) Alvin M. Brown, M.D.   |                                 | 22d. ADDRESS 233 Montebello Terrace, Belts 14   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 4-18-67  |                                 | 23b. DATE THEREOF   | 23c. NAME OF CEMETERY OR CREMATORIAL Mt. CARMEL                        | 23d. LOCATION (City or Town) Chicago                                | (County) (State) Ill.                  |
| 24. FUNERAL DIRECTOR HUNTT FUNERAL HOME, WALDORF, MD.   |                                 | ADDRESS.  | 25a. REC'D BY REGISTRAR APR 20 1967                                    | 25b. REGISTRAR'S SIGNATURE Charles Judge                            |  |

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**CERTIFICATE OF DEATH**

07640

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |                                  |  |  |   |   |   |                  |
|---|----------------------------------|--|--|---|---|---|------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b> MARYLAND  |                                  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY   |   |   |                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b>  |                                  | c. LENGTH OF STAY IN lb<br><b>21 days</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>  |   | d. STREET ADDRESS<br><b>Park Heights Ave</b>                                  |                  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Crownsville State Hospital</b>   |                                  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |                  |
| 3. NAME OF DECEASED<br>(Type or print) <b>#35137</b>  |                                  | First <b>Lucille</b>   | Middle <b>Simpson</b>                  | Lost  | 4. DATE OF DEATH<br>Month <b>4</b>  | Day <b>28</b>   | Year <b>1967</b> |
| S. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED<br>WIDOWED <input checked="" type="checkbox"/>  | NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10/14/10</b>   | 9. AGE (In years last birthday)<br><b>56 yrs.</b>                             | IF UNDER 1 YEAR<br>Months <b> </b> Days <b> </b> Hours <b> </b> Min. <b> </b> |                  |
| 7. DIVORCED <input type="checkbox"/>  |                                  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Labor</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>-----  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Dublin, Ireland</b> | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                    |                  |
| 13. FATHER'S NAME<br><b>Joseph Croghan</b>  |                                  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>McIntyre</b>   |   |   |                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>225-09-9005</b>  |  | 17. INFORMANT<br><b>Hospital Records</b>  |   | Address   |                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |                                  |  |  |   |   |   |                  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronicopneumonia</b> INTERVAL BETWEEN ONSET AND DEATH<br>191X  |                                  |  |  |   |   |   |                  |
| DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), (b) -----   |                                  |  |  |   |   |   |                  |
| stating the underlying cause (c) -----  |                                  |  |  |   |   |   |                  |
| DUE TO<br>last.   |                                  |  |  |   |   |   |                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                  |  |  |   |   |   |                  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |  |  |   |   |   |                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)<br>-----  |  |   |   |   |                  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. ----- P.M. -----  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>-----   |   | 20f. (City or town) (County) (State)<br>-----                                 |                  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>4/17/1967</b> to <b>4/28/1967</b> , that (I) (we) last saw the deceased alive on <b>4/28/1967</b> , and that death occurred at <b>11:00 AM</b> , from causes and on the date stated above. |                                  |  |  |   |   |   |                  |
| 22a. SIGNATURE<br><i>Seawell</i>  |                                  |  |  | 22b. DATE SIGNED<br>M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <b>5/10/67</b> |   |   |                  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>L. Benedict M.D.</b>   |                                  |  |  | 22d. ADDRESS<br><b>Crownsville State Hospital</b>   |   |   |                  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>MAY 17, 67</b>  |                                  | 23b. DATE THEREOF<br><b>MAY 17, 67</b>   |  | 23c. NAME OF CEMETERY OR CREMATORIALy<br><b>U. of Md. Med. School</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>        |                  |
| 24. FUNERAL DIRECTOR<br><b>William Reese II 108 W. WASH AVNW</b>  |                                  | ADDRESS  |  | 25a. REGD. BY REGISTRAR<br><b>JUN 7 1967</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                            |                  |

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #7 Film #G388 1/25/67 pc

04632

CERTIFICATE OF DEATH

04632

|  |                                  |  |   |   |   |
|--|----------------------------------|--|---|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY<br><b>Anne Arundel</b> MARYLAND   |                                  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE<br><b>473</b> |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b>   |                                  | c. LENGTH OF STAY IN lb<br><b>5yrs. 9mos.</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington, D.C.</b> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Crownsville State Hospital</b>  |                                  |  | d. STREET ADDRESS<br><b>202 N. Street, N.W.</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print)   | First<br><b>#23975</b>           | Middle<br><b>Cynthia</b>   | Last<br><b>Smith</b>  | 4. DATE OF DEATH<br>Month<br><b>4</b>   | Doy Year<br><b>16 19 67</b>   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>Negro</b> | 7. MARRIED<br>WIDOWED<br><b>UNK.</b>   | NEVER MARRIED<br>DIVORCED<br><b>UNK.</b>  | 8. DATE OF BIRTH<br><b>-/-/56</b>   | 9. AGE (In years<br>from last birthday)<br><b>11 yrs.</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Unknown</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>-----</b>  |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Unknown</b>                                       |   |
| 13. FATHER'S NAME<br><b>Unknown</b>  |                                  |  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>Unknown</b>   |                                  |  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>   | 17. INFORMANT<br><b>Hospital Records</b>  | Address   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (o)<br><b>ACUTE HEART FAILURE</b><br>4500<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost.<br>(b) <b>GENERALIZED ARTERIOSCLEROSIS</b><br>DUE TO<br>(c) |                                  |  |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)   |                                  |  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)<br>-----  |   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br><b>Hour a.m. ----- p.m. 19</b>   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)<br>-----                                | 20f. (City or town) (County) (State)<br>-----   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>7/27/1962</b> , to <b>4/16/1967</b> , that (I) (we) last saw the deceased alive on <b>4/16/1967</b> , and that death occurred at <b>1:25 P.M.</b> from causes and on the date stated above.   |                                  |  |   |   |   |
| 22a. SIGNATURE<br><b>L. Benedict M.D.</b>  |                                  |  |   |   |   |
| M.D. ATTENDING PHYS. P. MED. DIRECTOR STAFF PHYS. 22b. DATE SIGNED<br><b>4/17/67</b>   |                                  |  |   |   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>L. Benedict M.D.</b>  |                                  |  |   |   |   |
| 22d. ADDRESS<br><b>Crownsville State Hospital</b>  |                                  |  |   |   |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>4-21-17</b>   |                                  | 23b. DATE THEREOF<br><b>4-21-17</b>  | 23c. NAME OF CEMETERY OR CREMATORIUM<br><b>Harmony Park</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Landover Md</b>   |   |
| 24. FUNERAL DIRECTOR<br><b>Rollins - 4339 - Hunt Ph.</b>   |                                  |  | ADDRESS   | 25a. REC'D BY REGISTRAR<br><b>APR 20 1967</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |

08860

08860

FOR STATE  
HEALTH DEPT.

hours after death. If any delay is  
present, give Pages 1, 2, and 3 to  
the office along with form PM3. Page  
**I** and 2 will be the State Department  
death.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours, please execute the certificate, writing the word "pending" in pencil in the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office. 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial/transit permit. File pages Health prior to burial, cremation, or removal, and in any event within 72 hours after

VR A15ME (6M 1/67)

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2a,b,c & d Film #G388 5/3/67 b  
EXAMINED 12 CERTIFIED

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04633

|   |                                    |   |  |  |   |   |
|---|------------------------------------|---|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b>   |                                    |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>Anne Arundel |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b>  |                                    | c. LENGTH OF STAY IN lb   |  | d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville // Balto.</b> |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Crownsville State Hospital</b>   |                                    |   | e. STREET ADDRESS<br><b>536 W. Franklin St.<br/>Crownsville State Hospital</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED<br>(Type or print)  |                                    | First<br><b>HERBERT</b>   | Middle<br><b>M.</b>  | 4. DATE OF DEATH<br>Month<br><b>4</b>  | Day<br>Year<br><b>24 19 67</b>  |   |
| S. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Colored</b> | 7. MARRIED<br>WIDOWED <input type="checkbox"/>  | NEVER MARRIED <input checked="" type="checkbox"/><br>DIVORCED <input type="checkbox"/>   | 8. B. DATE OF BIRTH<br><b>3-23-26</b>  | 9. AGE (In years lost birthday)<br><b>41 yrs.</b>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                                    | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Chase City Va</b>  |   |   |
| 13. FATHER'S NAME<br><b>Solomon Smith</b>   |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Lillie Mae Gayles</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b>  |                                    | 16. SOCIAL SECURITY NO.<br><b>W</b>   |  | 17. INFORMANT<br><b>Lillie Mae Smith Lewis</b>   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypertensive and arteriosclerotic cardiovascular disease</b><br>XXX<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>disease</b><br>DUE TO<br>(c)   |                                    |   |  |  |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)  |                                    |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m.<br>p.m. <b>19</b>   |                                    | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                    |   |  |  |   | 22. DATE SIGNED<br><b>4-24-67</b>   |
| ACTUAL SIGNATURE<br><b>Russell S. Fisher</b>  |                                    | M.D.  |  | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   |   |
| EXAMINER'S NAME (Type)<br><b>RUSSELL S. FISHER, M.D.</b>  |                                    |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                    | 23b. DATE THEREOF<br><b>4-27-67</b>   |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>Mt. Auburn Cemt</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore</b>                                 |
| 24. FUNERAL DIRECTOR<br><b>Elvory O. Wilson 1000 Broadway Ave.</b>  |                                    | ADDRESS   |  | 25d. REC'D BY REGISTRAR  |   | 25e. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |
| DATE <b>APR 26 1967</b>   |                                    |   |  |  |   |   |

Leaven

January 1942

Bethesda

Inc. each month and you will

get a copy of the magazine.

Yours truly,

Inc. each month and you will

Yours truly,

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages and 25 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04634

## CERTIFICATE OF DEATH

04634

|  |                      |  |  |  |  |
|--|----------------------|--|--|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY ANNE ARUNDEL MARYLAND   |                      |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE MARYLA ND b. COUNTY BALTIMORE ✓          |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>FT GEO G MEADE   |                      | c. LENGTH OF STAY IN lb<br>9 days  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>BALTIMORE 30.4 |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>KIMBROUGH ARMY HOSPITAL  |                      |  | d. STREET ADDRESS<br>2901 HALCYON AVENUE e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 3. NAME OF DECEASED<br>(Type or print) First RUSSELL Middle W. SMITH, JR.  |                      | Lost   |  | 4. DATE OF DEATH<br>APRIL 6 19 67  |  |
| S. SEX MALE  | 6. COLOR OR RACE CAU | 7. MARRIED<br>WIDOWED  | NEVER MARRIED<br>DIVORCED  | 8. DATE OF BIRTH<br>5 SEPT 1946  | 9. AGE (In years lost birthday)<br>20 yrs.           |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>SERVICEMAN  |                      | 10b. KIND OF BUSINESS OR INDUSTRY<br>U.S. ARMY   |  | 11. BIRTHPLACE (County & State, or foreign country)<br>BALTIMORE, MD                               |  |
| 13. FATHER'S NAME<br>RUSSELL W. SMITH, SR.   |                      |  | 14. MOTHER'S MAIDEN NAME<br>ETHEL MAE SMITH ( STYERS)  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) Yes 20Jan65-6Apr67  |                      | 16. SOCIAL SECURITY NO.<br>219-42-7143   |  | 17. INFORMANT<br>2901 HALCYON AVE<br>RUSSELL W. SMITH, SR. BALTIMORE, MD                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>INFECTIOUS</u> DUE TO <u>092X</u> INTERVAL BETWEEN ONSET AND DEATH <u>10-14 days</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____<br>DUE TO _____ (c) _____ |                      |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                      |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. 19  |                      | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>                            | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |  |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>27 MAR 1967</u> , to <u>6 APR 1967</u> , that <input checked="" type="checkbox"/> (we) lost possession of the deceased alive on <u>6 APR 1967</u> , and that death occurred at <u>8:33 PM</u> , from causes and on the date stated above.                 |                      |  |  |  |  |
| 22a. SIGNATURE<br><u>Stuart H Brager</u>   |                      | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | 22b. DATE SIGNED<br>6 APRIL 67   |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br>STUART H. BRAGER, CPT, MC  |                      | 22d. ADDRESS<br>KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |                      | 23b. DATE THEREOF<br>4/11/67   | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Parkwood Cem.  | 23d. LOCATION (City or Town) (County) (State)<br>Balto. Md.  |  |
| 24. FUNERAL DIRECTOR<br>Harold S. Wally, Laurel, Maryland  |                      | ADDRESS  | 25a. REC'D. BY REGISTRAR<br>APR 10 1967  |  | 25b. REGISTRAR'S SIGNATURE<br>Harold S. Wally, Judge |

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100%

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04635

CERTIFICATE OF DEATH

04635

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>  |                                  | b. COUNTY<br><b>Anne Arundel</b>   |  |
| c. LENGTH OF STAY IN TB   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>                 |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Anne Arundel General Hospital</b>  |                                  | d. STREET ADDRESS<br><b>103 Tucker St.,</b>  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Katherine</b>  |                                  | First<br><b>Katherine</b>  | Middle<br><b></b>  |
| S. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED<br>WIDOWED <input checked="" type="checkbox"/>  | NEVER MARRIED <input type="checkbox"/><br>DIVORCED <input type="checkbox"/>                                      |
| 8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13. FATHER'S NAME<br><b>Spiro Soterakos</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Helen Soterakos</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.<br><b>219-40-8801A</b>   |  |
| 17. INFORMANT   |                                  | Address<br><b>Anthony Sterago (son) Fairfax, Va.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>Congestive heart failure</b>   |                                  | INTERVAL BETWEEN<br>ONSET AND DEATH<br><b>? years</b>  |  |
| DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause<br><b>4/20/</b><br>lost.   |                                  | 1 year<br>many<br>years  |  |
| (b) DUE TO<br><b>Myocardial infarctions, multiple</b>   |                                  |  |  |
| (c) DUE TO<br><b>Arteriosclerosis, coronary and general</b>   |                                  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Hypertension, Chronic pyelonephritis, pneumonia</b>  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                         |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m.<br>p.m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>            | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>(City or town) (County) (State)</b> |
| 21. I certify that (I) <b>Beall</b> offended the deceased from <b>26 Jan</b> , 19 <b>67</b> , to <b>Apr. 13</b> , 19 <b>67</b> , that (I) <b>Beall</b> last saw the deceased alive on <b>Apr. 13</b> , 19 <b>67</b> , and that death occurred at <b>M</b> , from causes and on the date stated above. |                                  | 6:15 PM  |  |
| 22a. SIGNATURE<br><b>Charles W. Kinzer</b>  |                                  | 22b. DATE SIGNED<br><b>14 Apr 1967</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Charles W. Kinzer, M.D.</b>  |                                  | 22d. ADDRESS<br><b>South River MedCent., Edgewater, Md.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>April 15, 67</b>   | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>St James Cemetery</b>   |
| 24. FUNERAL DIRECTOR<br><b>Beall Funeral Home</b>   |                                  | ADDRESS<br><b>12 West St<br/>Annapolis, Md.</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Annapolis, Md.</b>   |
| VR A15 (4)<br>25M 1/67  |                                  | 25e. REC'D BY REGISTRAR<br><b>APR 18 1967</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>J Charles Judge</b>   |

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04636

## CERTIFICATE OF DEATH

04636

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland, Anne Arundel</b>                               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b> 6 days  |   | c. LENGTH OF STAY IN lb<br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore 21225 - 021</b>                      |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Anne Arundel General Hospital</b>   |   | d. STREET ADDRESS<br><b>51 Pebble Drive Brooklyn Park</b>  |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  |  |
| 3. NAME OF DECEASED (Type or print)<br><b>Melvin Leroy STRAUSS -</b>   |   | First  | Middle   |
| 4. DATE OF DEATH<br><b>April 8, 1967</b>   | Month   | Day  | Year   |
| 5. SEX<br><b>male</b>  | 6. COLOR OR RACE<br><b>Cauc.</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>      | 8. DATE OF BIRTH<br><b>13 Oct 1918</b>   |
| 9. AGE (In years last birthday) yrs.<br><b>48</b>  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>SHEET METAL WORKER</b> | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland, Baltimore</b>  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |
| 13. FATHER'S NAME<br><b>AUGUST STRAUSS</b>   | 14. MOTHER'S MAIDEN NAME<br><b>ELENA (R) WILLIAMS</b>   | Address  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   | 16. SOCIAL SECURITY NO.<br><b>215-09-8846</b>   | 17. INFORMANT<br><b>SADIE E. STRAUSS (wife) - Same</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |   | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>331X</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)<br>stating the underlying cause (c)<br>last.  |   | <b>Cerebral hemorrhage</b> 6 days  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>None known</b>  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m.<br>19   |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <b>3 April 1967</b> , to <b>8 April 1967</b> , that (I) (we) last saw the deceased alive on <b>8 April 1967</b> , and that death occurred at <b>10:20 pm</b> from causes and on the date stated above. |   | 22b. DATE SIGNED<br><b>8 April 1967</b>  |  |
| 22c. SIGNATURE<br><b>Charles W. Kinzer</b>   |   | M.O. ATTENDING MED. STAFF<br>PHYS. DIRECTOR PHYS. <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Charles W. Kinzer, M. D.</b>  |   | 22d. ADDRESS<br><b>South River Medical Center Edgewater, Maryland 21037</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |   | 23b. DATE THEREOF<br><b>APR. 11, 1967</b>  | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>GLENDALE CEM.</b>   |
| 24. FUNERAL DIRECTOR<br><b>CURTIS E. EVANS</b>   |   | ADDRESS<br><b>1400 S. Charles St.</b>  | 25a. REC'D BY REGISTRAR<br>DATE<br><b>APR 10 1967</b>  |
|  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Evans</b>   |

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4** may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**04637**

**CERTIFICATE OF DEATH**

**04637**

|  |                              |  |   |
|--|------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b> MARYLAND   |                              | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> b. COUNTY<br><b>Anne Arundel</b>          |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Glen Burnie, Md.</b>  | c. LENGTH OF STAY IN 1b      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>North Linthicum</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>North Arundel Hospital</b>  |                              | d. STREET ADDRESS<br><b>28 Old Annapolis Road</b>  |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                              |  |   |
| 3. NAME OF DECEASED (Type or print)<br><b>Rose C. Susnowitz</b>  | First                        | Middle   | 4. DATE OF DEATH<br><b>April 8, 1967</b>  |
| 5. SEX<br><b>F</b>   | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED<br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>2-8-24</b>   |
| 9. AGE (In years lost birthday)<br><b>43 yrs.</b>  |                              | 10. IF UNDER 1 YEAR<br>Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>              |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Md.</b>                                    |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                              |  |   |
| 13. FATHER'S NAME<br><b>Michael J. Brannon</b>   |                              | 14. MOTHER'S MAIDEN NAME<br><b>Ethel M. Harvey</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                              | 16. SOCIAL SECURITY NO.  | 17. INFORMANT<br><b>Patients Chart</b> Address  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |                              |  |   |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>acute heart failure due to severe pulmonary</b> INTERVAL BETWEEN ONSET AND DEATH <b>2-3 days</b><br><b>5271</b><br>DUE TO <b>congestive emphysema &amp; myocardial damage</b> to 3 yrs<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>pre-Tonic reaction to</b><br>DUE TO <b>strangulated intestinal obstruction</b> 4 days<br>(c) |                              |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                              |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. <b>p.m.</b> 19   |                              | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>of work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>801 Crain Hwy S.E. Glen Burnie</b> |
| 20f. (City or town) <b>Baltimore, Md.</b> (County) <b>Anne Arundel</b> (State) <b>Md.</b>  |                              | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>4/8/67</b> to <b>4/8/67</b> , that (I) (we) last saw the deceased alive on <b>4/8/67</b> and that death occurred at <b>2:57 P.M.</b> from causes and on the date stated above.  |                              |  |   |
| 22a. SIGNATURE<br><b>Rose C. Susnowitz</b>   |                              | M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  | 22b. DATE SIGNED<br><b>4/8/67</b>   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Michael J. Brannon M.D.</b>   |                              | 22d. ADDRESS   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                              | 23b. DATE THEREOF<br><b>4-12-67</b>  | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>Balto. U. S. National</b>  |
| 23d. LOCATION (City or Town) <b>Baltimore, Md.</b> (County) <b>Anne Arundel</b> (State) <b>Md.</b>   |                              |  |   |
| 24. FUNERAL DIRECTOR<br><b>McCullly</b>  |                              | ADDRESS<br><b>130 E. Fort Ave</b>  | 25a. REC'D. BY REGISTRAR<br><b>APR 11 1967</b>  |
|  |                              |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04638

## CERTIFICATE OF DEATH

04638

|  |   |   |  |  |   |
|--|---|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY Anne Arundel MARYLAND   |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE Maryland b. COUNTY |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville   |   | c. LENGTH OF STAY IN lb<br>2mos. 14das.   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital  |   |   | d. STREET ADDRESS 2307 Belair Rd.  |  |   |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |  |  |   |
| 3. NAME OF DECEASED (Type or print) #34557 First Mamie Middle T. Lost Tennyson   | 4. DATE OF DEATH Month 4 Day 17 Year 1967 |   |  |  |   |
| S. SEX Female  | 6. COLOR OR RACE White                    | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6/19/90   | 9. AGE (In years <u>76</u> <small>last birthday</small> yrs.)                              | IF UNDER 1 YEAR Months Days Hours Min.            |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Former Teacher   |   | 10b. KIND OF BUSINESS OR INDUSTRY -----   |  | 11. BIRTHPLACE (County & State, or foreign country) Maryland                               |   |
| 13. FATHER'S NAME Thompson Donatius W.   |   |   | 14. MOTHER'S MAIDEN NAME Helen M. Morgan   |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) No  |   | 16. SOCIAL SECURITY NO. 220-14-7953   |  | 17. INFORMANT Hospital Records Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>pneumonia</u> INTERVAL BETWEEN ONSET AND DEATH<br><u>493X</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____<br>DUE TO _____<br>(c) _____<br>DUE TO _____<br>DUE TO _____ |   |   |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |   |   |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>-----   |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year <u>July 10</u> p.m. <u>75</u>   |   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) <u>A.</u> (County) <u>Baltimore</u> (State) <u>Md.</u>                 |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>2/7/</u> , 19 <u>67</u> , to <u>4/17/</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/17/</u> 19 <u>67</u> , and that death occurred at <u>12:50M</u> , fram causes and on the date stated above.  |   |   |  |  |   |
| 22a. SIGNATURE <u>L. Benedict, M.D.</u>  |   | 22b. DATE SIGNED <u>4/17/67</u>   |  |  |   |
| M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>   |   |   |  |  |   |
| 22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.   |   | 22d. ADDRESS Crownsville State Hospital, Maryland   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial   |   | 23b. DATE THEREOF 4/20/67   | 23c. NAME OF CEMETERY OR CREMATORIALy Redeemer Cem.  | 23d. LOCATION (City or Town) (County) (State) Balto. Md.                                   |   |
| 24. FUNERAL DIRECTOR Leonard J. Ruck Inc.  |   | ADDRESS Balto., Md.   |  | 25a. REC'D BY REGISTRAR APR 18 1967  | 25b. REGISTRAR'S SIGNATURE <u>Charles J. Ruck</u> |
| VR A15 (4)<br>20 M 1/66  |   |   |  | DATE   |   |

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FBI - NEW YORK  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE  
120 BROADWAY  
NEW YORK, N.Y. 10005  
TELEGRAMS: 230 PARK AVENUE  
TELEPHONE: 212-331-2600  
TWX: 910-350-1000  
TELEX: 23-7100  
FACSIMILE: 212-331-2600  
FAX: 212-331-2600  
E-MAIL: NYFBI@FBI.GOV  
INTERNET: NYFBI@FBI.GOV  
FBI - NEW YORK  
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FAX: 212-331-2600  
E-MAIL: NYFBI@FBI.GOV  
INTERNET: NYFBI@FBI.GOV

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04639

FOR STATE  
HEALTH DEMI

04639

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in part (b) of item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours of death.

|  |                              |  |   |   |   |   |                                      |                   |                  |  |                      |
|--|------------------------------|--|---|---|---|---|--------------------------------------|-------------------|------------------|--|----------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><i>A.A.Co.</i><br>MARYLAND   |                              | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><i>MD.</i><br>b. COUNTY<br><i>A.A.Co.</i>                 |   |   |   |   |                                      |                   |                  |  |                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>ANNAPOLIS</i>   |                              | c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><i>907 MONROE</i>                                   |   |   |   |   |                                      |                   |                  |  |                      |
| 3. NAME OF DECEASED<br>(Type or print)<br><i>Daisy</i>   |                              | First<br><i>H.</i>   | Middle<br><i>TRAUTMAN</i>                             |   |   |   |                                      |                   |                  |  |                      |
| 4. DATE OF DEATH<br><i>4 16 1967</i>   | Last<br><i>77</i>            | Month<br><i>4</i>  | Day<br><i>16</i>                                      | Year<br><i>1967</i>   |   |   |                                      |                   |                  |  |                      |
| 5. SEX<br><i>F</i>   | 6. COLOR OR RACE<br><i>W</i> | 7. MARRIED<br>WIDOWED<br><input checked="" type="checkbox"/>   | NEVER MARRIED<br>DIVORCED<br><input type="checkbox"/> | 8. DATE OF BIRTH<br><i>8-28-1895</i>  | 9. AGE (In years<br>last birthday)<br>yrs.<br><i>77</i> | IF UNDER 1 YEAR<br>Months<br><i>0</i>                                       | IF UNDER 24 HRS.<br>Days<br><i>0</i> | Hours<br><i>0</i> | Min.<br><i>0</i> |  |                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>HOME</i>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>HOUSEWIFE</i>  |   | 11. BIRTHPLACE (State or foreign country)<br><i>BARRY TOWNSHIP, PA.</i>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>                                 |                                      |                   |                  |  |                      |
| 13. FATHER'S NAME<br><i>JACOB HOFFMAN</i>  |                              | 14. MOTHER'S MAIDEN NAME<br><i>ELIZABETH WEIST</i>   |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><i>No</i> |   | 16. SOCIAL SECURITY NO.<br><i>121 22 9470A</i>                              |                                      |                   |                  | 17. INFORMANT<br><i>LEAH M. McCARTHY #2</i>  | Address<br><i>#2</i> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |                              |  |   |   |   |   |                                      |                   |                  | INTERVAL BETWEEN ONSET AND DEATH<br><i>Unknown</i>   |                      |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><i>4500</i><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO<br>(c)   |                              |  |   |   |   |   |                                      |                   |                  | <i>arteriosclerosis generalized</i>  |                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                              |  |   |   |   |   |                                      |                   |                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                      |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |   |   |   |                                      |                   |                  |  |                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m.<br>p.m.<br><i>19</i>   |                              | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>of work <input type="checkbox"/> at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town)<br>(County)<br>(State)                                  |                                      |                   |                  |  |                      |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                              |  |   |   |   |   |                                      |                   |                  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br><i>S. Schubert</i><br>M.D.  |                      |
|  |                              |  |   |   |   |   |                                      |                   |                  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county)<br><i>446-67</i> |                      |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><i>BURIAL</i>  |                              | 23b. DATE THEREOF<br><i>4-18-67</i>  |   | 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS<br><i>HILLCREST</i>  |   | 23d. LOCATION (City or Town)<br>(County)<br>(State)<br><i>ANNAPOLIS MD.</i> |                                      |                   |                  |  |                      |
| 24. FUNERAL DIRECTOR<br><i>John M. Taylor &amp; Sons Annapolis, Md.</i>  |                              |  |   | 25a. RECD BY REGISTRAR<br>DATE<br><i>APR 18 1967</i>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                          |                                      |                   |                  |  |                      |

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ELIZABETH WALTERS HOMESTEAD

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Amnabots

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11/16/1991 (Monrovia) 11/16/1991 (Monrovia)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04640

CERTIFICATE OF DEATH

04640

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |   |   |  |   |   |                                     |           |
|--|--|---|---|--|---|---|-------------------------------------|-----------|
| 1. PLACE OF DEATH<br>o. COUNTY   |  | Anne Arundel MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE Maryland |   | b. COUNTY Anne Arundel  |                                     |           |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |  | c. LENGTH OF STAY IN Tb<br>Annapolis 4 days   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>RURAL - Annapolis      |   | d. STREET ADDRESS<br>Rt-2, Box-299                                |                                     |           |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)   |  | Anne Arundel General Hospital   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |   |   |                                     |           |
| 3. NAME OF DECEASED (Type or print)  |  | First Henry   | Middle Williams   | Last Trott   | 4. DATE OF DEATH                            | Month April   | Day 8                               | Year 1967 |
| 5. SEX Male  |  | 6. COLOR OR RACE White  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH<br>April 8, 1893  | 9. AGE (In years, last birthday)<br>74 yrs. | IF UNDER 1 YEAR<br>Months   | IF UNDER 24 HRS.<br>Days Hours Min. |           |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Supervisor  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>County Roads   |   | 11. BIRTHPLACE (County & State, or foreign country)<br>CALVERT Co. Maryland                                |   | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.                              |                                     |           |
| 13. FATHER'S NAME Robert Trott   |  | 14. MOTHER'S MAIDEN NAME Unknown  |   |  |   |   |                                     |           |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |  | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br>PEARL L Trott #2  |   | Address   |                                     |           |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CUTTEREAL THROMBOSIS</u> DUE TO <u>332X</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____<br>stating the underlying cause (c) _____<br><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>ARTERIOSCLEROSIS, GENERALIZED GANGRENE RT LEG</u> |  |   |   |  |   |   |                                     |           |
| 19a. MEDICAL CERTIFICATION<br>ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 19b. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>        |   |  |   |   |                                     |           |
| 20a. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. _____ 19  |  | 20b. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                     |   | 20d. (City or town) (County) (State)                              |                                     |           |
| 21. I certify that (I) <u>Edward S. Beck</u> attended the deceased from <u>Jan 1</u> , 19 <u>59</u> , to <u>April 8</u> , 19 <u>67</u> , that (I) <u>(He)</u> last saw the deceased alive on <u>April 8</u> , 19 <u>67</u> , and that death occurred at <u>_____</u> M, fram causes and on the date stated above.  |  | 22a. SIGNATURE<br><u>Edward S. Beck</u>   |   | 22b. DATE SIGNED<br>8:00 PM<br>4-10-67   |   |   |                                     |           |
| 22c. PHYSICIAN'S NAME (Type)<br>Edward S. Beck, M.D.   |  | 22d. ADDRESS<br>73 Franklin St., Annapolis, Md.   |   |  |   |   |                                     |           |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 23b. DATE THEREOF<br>4/11/1967  |   | 23c. NAME OF CEMETERY OR CREMATORIUM<br>CEDAR BLUFF CEM.   |   | 23d. LOCATION (City or Town)<br>ANNAPOLIS (County) (State)<br>MD. |                                     |           |
| 24. FUNERAL DIRECTOR<br>John M. Taylor Sons Annapolis MD.  |  | ADDRESS   |   | 25a. RECEIVED BY REGISTRAR<br>APR 12 1967  |   | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge                       |                                     |           |

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04641

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04641

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b>                          |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Glen Burnie</b>  |  | c. LENGTH OF STAY IN 1b<br>MARYLAND   |   |
| d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Glen Burnie</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>NORTH ARUNDEL GENERAL HOSPITAL - DOA</b>   |  | d. STREET ADDRESS<br><b>11 Virginia Avenue</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br><b>JEROME GEORGE VACEK</b>   |  | First<br><b>JEROME</b>  | Middle<br><b>GEORGE</b>   |
| 3. NAME OF DECEASED (Type or print)<br><b>JEROME GEORGE VACEK</b>   |  | Lost<br><b>VACEK</b>  | 4. DATE OF DEATH<br>Month<br><b>4</b>   |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH<br><b>9-1-42</b>   |  | 9. AGE (In years last birthday)<br><b>24 yrs.</b>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Bowling Alley Mechanic</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Bowling</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |   |
| 13. FATHER'S NAME<br><b>James Vacek</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Ludicke</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No.</b>   |  | 16. SOCIAL SECURITY NO.<br><b>217-38-5609</b>   |   |
| 17. INFORMANT<br><b>Phyllis Vacek</b>   |  | Address<br><b>11 Virginia Av. (Wife</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Massive internal bleeding</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>982X</b><br>(b) <b>Stab wounds of chest</b><br>DUE TO<br>(c)   |  |   |   |
| INTERVAL BETWEEN ONSET AND DEATH  |  |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)<br><b>Stabbed during altercation with friend</b> |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m.<br><b>2:00 xxix 4 4 1967</b>  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>                             | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>House</b>  |
|   |  | 20f. (City or town)<br><b>Glen Burnie</b>   | (County)<br><b>A.A.</b>   |
|   |  | (State)<br><b>Md.</b>   |   |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |   |   |
| ACTUAL SIGNATURE<br><i>Werner U. Spitz</i>  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>M.D.   | 22. DATE SIGNED<br><b>4-4-67</b>  |
| EXAMINER'S NAME (Type)<br><b>WERNER U. SPITZ, M.D.</b>  |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/>                            | Address (Street, city, town, or county)   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>4/7/1967</b>  | 23c. NAME OF CEMETERY OR CREMATORIALy<br><b>Lake View Mem. Park</b>   |
|   |  | 23d. LOCATION (City or Town)<br><b>Carroll County, Md.</b>  | (County)<br>(State)   |
| 24. FUNERAL DIRECTOR<br><b>Raymond C. Fink</b>  |  | ADDRESS<br><b>Glen Burnie, Md.</b>  | 25a. REC'D BY REGISTRAR<br><b>APR 6 1967</b>  |
|   |  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

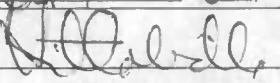
04642

CERTIFICATE OF DEATH

04642

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |                                  |  |   |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b>   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>  |                                  | b. COUNTY<br><b>Anne Arundel</b>   |   |
| c. LENGTH OF STAY IN TB   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Glen Burnie</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Anne Arundel General Hospital</b>  |                                  | d. STREET ADDRESS<br><b>307 First Ave., S. W.</b>  |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |  |   |
| 3. NAME OF DECEASED<br>(Type or print)  | First<br><b>Robert</b>           | Middle<br><b>A.</b>  | Last<br><b>VOLKHARDT</b>  |
| 4. DATE OF DEATH  | Month<br><b>April</b>            | Day<br><b>7</b>  | Year<br><b>19 67</b>  |
| S. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED<br><input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH<br><b>July 10, 1894</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Offer Worker</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Refractory</b>   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Pennsylvania</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>   |   |
| 13. FATHER'S NAME<br><b>George Volkhart</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Emma (Unknown)</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>yes</b> <b>WW I</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>195-05-0095</b> 17. INFORMANT<br><b>Mrs. Betty McCray (Daughter)</b> Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>perforated duodenal ulcer</b> DUE TO <b>541.1</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>stress secondary to</b><br>stating the underlying cause (c) <b>aortic aneurism resection</b> |                                  |  |   |
| INTERVAL BETWEEN ONSET AND DEATH  |                                  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m.<br>p.m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>11:00 A.M.</b> |
| 20f. (City or town)<br>(County)<br>(State)  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>19</b> , to <b>19</b> , that (I) (we) last saw the deceased alive on <b>Apr. 7 1967</b> , and that death occurred at <b>M.</b> from causes and on the date stated above.   |                                  |  |   |
| 22a. SIGNATURE<br>   |                                  | 22b. DATE SIGNED<br><b>22d. ADDRESS<br/>Stephen B. Hiltabidle M.D., 121 Cathedral St., Annapolis, Md.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>4/11/67</b>  | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>Chester Cemetery</b>                             |
| 23d. LOCATION (City or Town)<br><b>Chester.</b>   |                                  | (County) (State)<br><b>Pa.</b>   |   |
| 24. FUNERAL DIRECTOR<br><b>Robert P. Kelly</b><br><b>Singleton Funeral Home/Glen Burnie, Md.</b>  |                                  | 25a. ADDRESS<br><b>Singlelon Funeral Home/Glen Burnie, Md.</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |
| 25m 1/67  |                                  | 25a. REC'D BY REGISTRAR<br><b>APR 10 1967</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |



1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |  |  |   |                  |  |                     |                      |  |      |  |
|--|--|--|--|---|------------------|--|---------------------|----------------------|--|------|--|
| CERTIFICATE OF DEATH   |  |  |  |   |                  |  |                     |                      |  |      |  |
| 1. PLACE OF DEATH<br>a. COUNTY   |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)<br>b. STATE                                    |   |                  |  |                     |                      |  |      |  |
| A. A. County Maryland  |  |  | MD   |   |                  |  |                     |                      |  |      |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>C. LENGTH OF STAY IN 1b  |  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)   |   |                  |  |                     |                      |  |      |  |
| Baltimore 15 years   |  |  | Baltimore 221  |   |                  |  |                     |                      |  |      |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)   |  |  | d. STREET ADDRESS  |   |                  |  |                     |                      |  |      |  |
| 213 Calypso Ave  |  |  | 213 Calypso Rd   |   |                  |  |                     |                      |  |      |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |   |                  |  |                     |                      |  |      |  |
| 3. NAME OF DECEASED (Type or print)  |  |  | First  | Middle  | Last             | 4. DATE OF DEATH   | Month               | Day                  | Year   |      |  |
| Helen  |  |  | C  | Wade  |                  | 4-9-67   |                     |                      |  | 19   |  |
| 5. SEX   |  |  | 6. COLOR OR RACE   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (in years last birthday)  | 10. IF UNDER 1 YEAR | 11. IF UNDER 24 HRS. |  |      |  |
| F  |  |  | W  | WIOOWEO <input type="checkbox"/>  | 8-21-17          | 54 yrs.  | Months              | Days                 | Hours  | Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |   |                  | 11. BIRTHPLACE (County & State, or foreign country)                    |                     |                      | 12. CITIZEN OF WHAT COUNTRY  |      |  |
| Housewife Home   |  |  |  |   |                  | Md.  |                     |                      | USA  |      |  |
| 13. FATHER'S NAME  |  |  | 14. MOTHER'S MAIDEN NAME   |   |                  |  |                     |                      |  |      |  |
| Robert Hark  |  |  | Myrtle Holmes  |   |                  |  |                     |                      |  |      |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |  |  | 16. SOCIAL SECURITY NO.  |   |                  | 17. INFORMANT  |                     |                      | Address  |      |  |
| No   |  |  | —  |   |                  | H. Melvin Wade   |                     |                      | Alma   |      |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  |  |  | PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)  |   |                  | Congestive Heart Failure   |                     |                      | INTERVAL BETWEEN ONSET AND DEATH   |      |  |
| 410 X  |  |  | DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                             |   |                  | Mild Stenosis  |                     |                      |  |      |  |
| (b)  |  |  | DUE TO   |   |                  | Rheumatic Heart Disease  |                     |                      |  |      |  |
| (c)  |  |  |  |   |                  |  |                     |                      |  |      |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |  |  |   |                  |  |                     |                      |  |      |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |                  |  |                     |                      | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |      |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m.<br>p.m.  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>                            |   |                  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |                     |                      | 20f. (City or town) (County) (State)   |      |  |
| 19   |  |  |  |   |                  |  |                     |                      |  |      |  |
| 21. I certify that (I) (this hospital) attended the deceased from 1957, 19, to 1967, 19, that (I) (we) last saw the deceased alive on 4-8-67 19 and that death occurred at 1A M, from the causes and on the date stated above. |  |  |  |   |                  |  |                     |                      |  |      |  |
| 22a. SIGNATURE   |  |  |  |   |                  |  |                     |                      | 22b. DATE SIGNED   |      |  |
| Robert R. Holmes   |  |  |  |   |                  |  |                     |                      |  |      |  |
| 22c. PHYSICIAN'S NAME (Type)   |  |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   |                  | 22d. ADDRESS   |                     |                      | P.O. Box 73 Severna Park   |      |  |
| General  |  |  |  |   |                  |  |                     |                      |  |      |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  | 23b. DATE THEREOF  |   |                  | 23c. NAME OF CEMETERY OR CREMATORIAL                                   |                     |                      | 23d. LOCATION (City, town or county) (State)   |      |  |
| General  |  |  | 4-12-67  |   |                  | Glen Haven   |                     |                      | Glen Burnie  |      |  |
| 24. FUNERAL DIRECTOR   |  |  | ADDRESS  |   |                  | 25a. REC'D BY REGISTRAR  |                     |                      | 25b. REGISTRAR'S SIGNATURE   |      |  |
| Robert J. Beranek, Severna Park Rd   |  |  |  |   |                  |  |                     |                      | APR 12 1967 Charles Judge  |      |  |
| VR A15 (4)<br>20M 1/65   |  |  |  |   |                  |  |                     |                      |  |      |  |

61340



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04644

CERTIFICATE OF DEATH

04644

|  |  |  |   |  |  |
|--|--|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY Anne Arundel MARYLAND   |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE Maryland  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville   |  |  | c. LENGTH OF STAY IN lb<br>6mos 14days  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |
| 3. NAME OF DECEASED First James Washington   |  |  | 4. DATE OF DEATH Month 4 Doy 10 Year 1967   |  |  |
| 5. SEX Male Negro  |  |  | 6. COLOR OR RACE 7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown  |  |  | 8. DATE OF BIRTH July, 16/1967<br>9. AGE (In years 21 last birthday) 45 yrs.  |  |  |
| 10b. KIND OF BUSINESS OR INDUSTRY -----  |  |  | 11. BIRTHPLACE (County & State, or foreign country) Maryland  |  |  |
| 13. FATHER'S NAME Ben Washington   |  |  | 12. CITIZEN OF WHAT COUNTRY? USA  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No   |  |  | 16. SOCIAL SECURITY NO. None  |  |  |
| 17. INFORMANT Hospital Records Address   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (o) Pulmonary Edema, Congestion and Atelectasis   |  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |  |
| Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last.<br>(b) Pulmonary embolism, Lt. Pulmonary artery branch<br>(c) Phlebothrombosis, Lt. Peri-Prostatic Veins                          |  |  |   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)<br>Mental Deficiency  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>-----   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. ----- p.m. -----   |  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not White <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |  | 20f. (City or town) (County) (State)  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from 9/24/1966 to 4/10/1967, that (I) (we) last saw the deceased alive on 4/10/1967, and that death occurred at 10:35A.M. from causes and on the date stated above. |  |  |   |  |  |
| 22a. SIGNATURE <i>L. Benedict</i>  |  |  | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> DATE SIGNED 4/11/67    |  |  |
| 22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.   |  |  | 22d. ADDRESS Crownsville State Hospital, Md.  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial   |  |  | 23b. DATE THEREOF April, 15, 1967   |  |  |
| 23c. NAME OF CEMETERY OR CREMATORIUM Bethel Cemetery   |  |  | 23d. LOCATION (City or Town) (County) (State) Rural, Chestertown, Md.   |  |  |
| 24. FUNERAL DIRECTOR Edward Fellows  |  |  | ADDRESS Millington, Md.   |  |  |
| VR A15 (4)<br>20 M 1/66  |  |  | 25a. RECD BY REGISTRAR APR 18 1967  |  |  |
|  |  |  | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>   |  |  |

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04645

## CERTIFICATE OF DEATH

04645

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>A Anne Arundel</b><br>MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Anne Arundel</b>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Glen Burnie</b>  |   | c. LENGTH OF STAY IN 1b<br>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>North Arundel Hospital,</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 3. NAME OF DECEASED<br>(Type or print)  | First<br><b>Mary</b>                      | Middle<br><b>Marcille</b>  | Last<br><b>Watts</b>  |
| 4. DATE OF DEATH  | Month<br><b>April</b>                     | Day<br><b>7</b>  | Year<br><b>1967</b>   |
| 5. SEX<br><b>F</b>  | 6. COLOR OR RACE<br><b>Cau.</b>           | 7. MARRIED<br>WIDOWED <input type="checkbox"/><br>NEVER MARRIED <input checked="" type="checkbox"/><br>DIVORCED <input type="checkbox"/>                       | 8. DATE OF BIRTH<br><b>7 Sept 1914</b>                                    |
| 9. AGE (In years<br>last birthday)<br><b>52 yrs.</b>  | 10. IF UNDER 1 YEAR<br>Months<br><b> </b> | 11. IF UNDER 24 HRS.<br>Days<br><b> </b>   | 12. IF UNDER 24 HRS.<br>Hours<br><b> </b>                                 |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br><b>Sales Clerk</b>  |   | 10b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>Store</b>   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>  |   | 12. CITIZEN OF WHAT<br>COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Charles M. Morgan</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Florence (unknown)</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |   | 16. SOCIAL SECURITY NO.<br><b>218-47-1640</b>  |   |
| 17. INFORMANT<br><b>Earl Watts</b>  |   | Address<br><b>1030 Cayer Drive Glen Burnie</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>1201</b><br>DUE TO<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. (b)<br>DUE TO<br>(c) |   | INTERVAL BETWEEN<br>ONSET AND DEATH<br><b>Acute Coronary Thrombosis</b><br><b>Advanced A.S.D.</b>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)  |   |  |   |
| 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m.<br>p.m.      19   |   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm,<br>factory, street, office bldg., etc.) |
| 20f. (City or town)<br>(County)<br>(State)  |   |  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Sept</b> , 19 <b>65</b> , to <b>4/6</b> , 19 <b>67</b> , that (I) (we) last<br>saw the deceased alive on <b>4/6</b> 19 <b>67</b> , and that death occurred at <b>M</b> , from causes and on the date stated above.   |   |  |   |
| 22a. SIGNATURE<br><b>Wayne B. Jato</b>  |   | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/><br>MED. DIRECTOR <input type="checkbox"/><br>STAFF PHYS. <input type="checkbox"/>                     | 22b. DATE SIGNED<br><b>4/8/67</b>   |
| 22c. PHYSICIAN'S NAME (Type)  |   | 22d. ADDRESS   |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>   |   | 23b. DATE THEREOF<br><b>April 11, 1967</b>   | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>Glen Haven Memorial PA</b>     |
| 23d. LOCATION (City or Town)<br>(County)<br>(State)   |   | 23e. ADDRESS<br><b>Singleton Funeral Home</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>R.V. Singleton</b>   |   | 25a. REC'D BY REGISTRAR<br>DATE<br><b>APR 12 1967</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                        |

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Page 6 of 114 - 3rd Grade

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04646

## CERTIFICATE OF DEATH

04646

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |                              |   |   |   |  |   |
|---|------------------------------|---|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY Anne Arundel MARYLAND  |                              |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE Md. 21213 b. COUNTY _____ |   |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Severna Park</b>   |                              | c. LENGTH OF STAY IN 1b   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>    |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>_____   |                              |   | d. STREET ADDRESS<br><b>3517 Elmley Ave.</b>  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br><b>Mary</b> First <b>Delores</b> Middle <b>Weber</b> Last  |                              |   | 4. DATE OF DEATH<br><b>April 21 1967</b>  |   |  | Month Day Year  |
| S. SEX<br><b>F</b>  | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED<br>WIDOWED <input checked="" type="checkbox"/>   | NEVER MARRIED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>4/22/1913</b>  | 9. AGE (In years<br>last birthday)<br><b>53</b> yrs. | IF UNDER 1 YEAR<br>Months Days Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Clerical Work</b>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Stewart &amp; Co.</b>   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Md.</b>                            |  | 12. CITIZEN OF WHAT COUNTRY?  |
| 13. FATHER'S NAME<br><b>Frank S. Savorski</b>   |                              |   | 14. MOTHER'S MAIDEN NAME<br><b>Ellen Noonan</b>   |   |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |                              | 16. SOCIAL SECURITY NO.<br><b>215-40-9351</b>   |   | 17. INFORMANT <b>Severna Pk, Md.</b> Address <b>21146</b><br><b>John F. Weber, son, 272 Pertsch Rd.</b> |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Carcinoma of the lung with metastasis</i> DUE TO <i>163X</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>                               |                              |   |   |   |  |   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO  |                              |   |   |   |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                              |   |   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |   |   |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. P.M. 19   |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                  |  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Mar. 24</b> , 1967, to <b>April 21, 1967</b> , that (I) (we) last saw the deceased alive on <b>April 14 1967</b> , and that death occurred at <b>7:55 AM</b> , from causes and on the date stated above. |                              |   |   |   |  | 22b. DATE SIGNED<br><b>4/21/67</b>  |
| 22a. SIGNATURE<br><i>Ray M. Smith</i>   |                              | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>  |   | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Ray M. Smith, M. D.</b>  |                              | 22d. ADDRESS<br><b>Hahn Professional Bldg., Severna Pk., Md.</b>  |   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                              | 23b. DATE THEREOF<br><b>4/24/67</b>   |   | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>Holy Redeemer Cem.</b>                                       |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>                            |
| 24. FUNERAL DIRECTOR<br><b>Schimunek Funeral Home, Inc.</b><br>3331 Brehms Land   |                              | ADDRESS   |   | 25a. REGISTRATION NUMBER<br><b>APR 21 1967</b> 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>         |  |   |
|   |                              |   |   | DATE  |  |   |

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04647

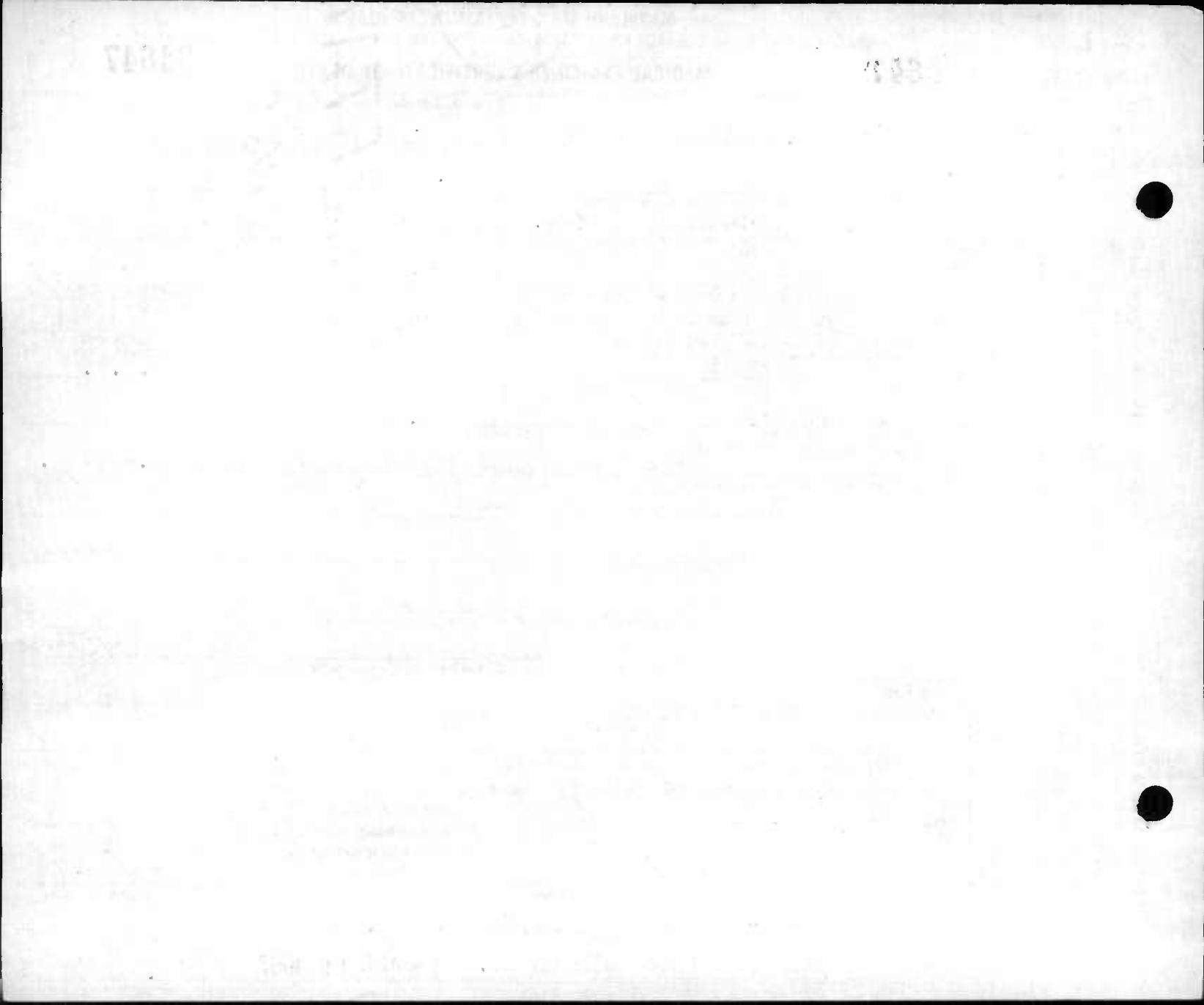
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04647

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE         |   |
| ANNE ARUNOEL - County Maryland   |  | b. COUNTY   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>91st Street  |  | c. LENGTH OF STAY IN lb   |   |
| d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Baltimore  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Baltimore             |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>D.O.A.-North. ARUNOEL - Hospital.  |  | d. STREET ADDRESS<br>1024 N. Gilmore Street   |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |   |
| 3. NAME OF DECEASED<br>(Type or print)   |  | First<br><i>Edward</i>  | Middle<br><i>n</i>  |
| 3. NAME OF DECEASED<br>(Type or print)   |  | Lost<br><i>Weems</i>  | 4. DATE OF DEATH<br>Month<br><i>+ 18</i>  |
| 5. SEX<br><i>M</i>   |  | 6. COLOR OR RACE<br><i>N</i>  | 7. MARRIED<br><input checked="" type="checkbox"/> NEVER MARRIED<br><input type="checkbox"/><br>WIDOWED<br><input type="checkbox"/> DIVORCED<br><input type="checkbox"/> |
| 8. DATE OF BIRTH<br><i>8-29-23</i>   |  | 9. AGE (In years last birthday)<br><i>43</i> yrs.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |   |
| 13. FATHER'S NAME<br><i>Robert Weems</i>   |  | 14. MOTHER'S MAIDEN NAME<br><i>M. Lee</i>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><i>yes</i>   |  | 16. SOCIAL SECURITY NO.<br><i>R12203934</i>   |   |
| 17. INFORMANT<br><i>Evelyn Weems 1024 Gilmore St.-Balto.</i>   |  | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (o)<br><i>1344</i><br><i>Cardiac disease</i>  |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>sudden</i>   |   |
| Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost.<br>(b)<br>(c)   |  | DUE TO<br><i>DUE TO</i>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)   |  |   |   |
| 20a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m.<br>p.m.<br><i>19</i>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><i>Baltimore, Nat'l. Cem.</i>   |
| 20f. (City or town)<br><i>Baltimore</i>  |  | (County)<br><i>Maryland</i>   |   |
| (State)<br><i>MD</i>   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |   |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |   |   |
| ACTUAL SIGNATURE<br><i>E. Linhardt</i>   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |
| EXAMINER'S NAME (Type)<br><i>E. Linhardt</i>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |
|  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   |
|  |  | Address (Street, city, town, or county)<br><i>Baltimore, Maryland</i>                                     |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><i>Burial</i>  |  | 23b. DATE THEREOF<br><i>4-21-67</i>   | 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS<br><i>Baltimore, Nat'l. Cem.</i>   |
| 23d. LOCATION (City or Town)<br><i>Baltimore</i>   |  | (County)<br><i>Maryland</i>   |   |
| (State)<br><i>MD</i>   |  | 25a. REC'D BY REGISTRAR<br><i>APR 19 1967</i>   |   |
| 24. FUNERAL DIRECTOR<br><i>Kelson Funeral Home 1348 Calhoun St.</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |   |



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1, 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #12 Film #G367 4/11/67 pc

04648

CERTIFICATE OF DEATH

04648

|   |                              |  |  |  |   |
|---|------------------------------|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b>  |                              |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hollywood</b>  |                              | c. LENGTH OF STAY IN lb<br><b>15 days</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>           |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Hollywood Hospital</b>   |                              |  | d. STREET ADDRESS<br><b>3809 Baltimore Ave.</b>  |  |   |
|   |                              |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                       |  |   |
| 3. NAME OF DECEASED (Type or print)<br><b>Tekla Wiflin</b>  |                              |  | First  | Middle   | Last  |
| S. SEX<br><b>F</b>  | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED<br>WIDOWED <input type="checkbox"/>   | NEVER MARRIED<br>DIVORCED <input checked="" type="checkbox"/>  | 8. DATE OF BIRTH<br><b>9-23-94</b>   | 9. AGE (In years<br>last birthday)<br>yrs.<br><b>72</b>                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>  |                              |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (Country & State, or foreign country)<br><b>Thailand</b> |
| 13. FATHER'S NAME<br><b>Albert</b>  |                              |  | 14. MOTHER'S MAIDEN NAME<br><b>TEKLA Garsell</b>   |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |                              |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br><b>Family - Son</b>                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary edema</b><br>4001<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Congestive heart failure</b><br>DUE TO<br>(c) <b>Coronary artery thrombosis</b><br>DUE TO |                              |  |  |  |   |
| INTERVAL BETWEEN ONSET AND DEATH<br><b>1 week</b>   |                              |  |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Arteriosclerosis and recent cerebral thrombosis</b>  |                              |  |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m.<br>p.m. 19  |                              | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>         |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State) |   |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at _____ M, from causes and on the date stated above.   |                              |  |  |  |   |
| 22a. SIGNATURE<br><b>Ray M. Smith</b>   |                              |  |  |  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Ray M. Smith, M. D.</b>  |                              | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED<br><b>4-8-67</b> |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>4-10-67</b>   |                              | 23b. DATE THEREOF<br><b>4-10-67</b>  |  | 23c. NAME OF CEMETERY OR CREMATORIAL FACILITY<br><b>Holy Cross</b>   |   |
| 24. FUNERAL DIRECTOR<br><b>McClellan - 237</b>  |                              | ADDRESS<br><b>Paragon Sec Line</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE<br><b>APR 11 1967</b>  |   |
|   |                              |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   |

8130 Brooklyn Ave.

7-1330

200-130-154

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                                  |  |  |  |                                     | 04649   |                    |                     |
|---|----------------------------------|--|--|--|-------------------------------------|---|--------------------|---------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b>   |                                  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> |  |                                     | b. COUNTY<br><b>Anne Arundel</b>  |                    |                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>ANNAPOLIS</b>  |                                  | c. LENGTH OF STAY IN lb  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Harwood</b> |                                     | d. STREET ADDRESS<br><b>WESTON FARMS</b>  |                    |                     |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Anne Arundel General Hospital (DOA)</b>  |                                  |  | d. STREET ADDRESS<br><b>Western Farms</b>  |  |                                     | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                    |                     |
| 3. NAME OF DECEASED<br>(Type or print)  |                                  | First<br><b>HARRY</b>  | Middle<br><b>H.</b>  | Lost   | 4. DATE OF DEATH<br><b>April 21</b> | Month   | Doy                | Year<br><b>1967</b> |
| S. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED<br><input checked="" type="checkbox"/> NEVER MARRIED<br><input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    | 8. DATE OF BIRTH<br><b>1886</b><br><b>Dec. 3, 1887/1</b>   | 9. AGE (In years lost birthday)<br><b>80</b>   | IF UNDER 1 YEAR<br>Months           | IF UNDER 24 HRS<br>Days   | Hours              | Min.                |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>FARMER</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>TOBACCO</b>  | 11. BIRTHPLACE (State or foreign country)<br><b>CWASH, D.C.</b>  |  |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                    |                     |
| 13. FATHER'S NAME<br><b>James F. Wood</b>   |                                  |  | 14. MOTHER'S MAIDEN NAME<br><b>ROSE NOWELL SHORTER</b>   |  |                                     |   |                    |                     |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <input type="checkbox"/>   |                                  | 16. SOCIAL SECURITY NO.<br><b>217-30-3317</b>  |  | 17. INFORMANT<br><b>Della Wood, Harwood, Md</b>  |                                     | Address   |                    |                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>Asphyxia</b><br><b>912.1</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b)      DUE TO <b>Compression of airway</b><br>(c)      DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |                                  |  |  |  |                                     |   |                    |                     |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                  |  |  |  |                                     |   |                    |                     |
| 20a. EXTERNAL CAUSE WAS<br>PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Overturned tractor caused compression of airway</b>                               |  |  |                                     |   |                    |                     |
| 20c. TIME OF INJURY Month, Day, Year<br><b>Hour 20C<br/>5:00 p.m. 4-21 1967</b>   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input checked="" type="checkbox"/><br>at work <input checked="" type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Farm</b>              |                                     | 20f. (City or town) <b>Harwood-Weston</b>   | (County) <b>AA</b> | (State) <b>Md</b>   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>                             |                                  |  |  |  |                                     |   |                    |                     |
| ACTUAL SIGNATURE<br><i>Charles S. Springate</i>   |                                  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/>                |  |  |                                     |   |                    |                     |
| EXAMINER'S NAME (Type)<br><b>Charles S. Springate, M.D.</b>   |                                  | 22. DATE SIGNED<br><b>4-22-67</b>  |  |  |                                     |   |                    |                     |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>4-25-67</b>  |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>Mt Zion</b>   |                                     | 23d. LOCATION (City or Town) (County) (State)<br><b>Luthan Md</b>                                 |                    |                     |
| 24. FUNERAL DIRECTOR<br><b>T. Harroldy - Galesville, Md</b>   |                                  | ADDRESS  |  | 25a. REC'D BY REGISTRAR<br><b>APR 25 1967</b>  |                                     | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |                    |                     |

2000

2000

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4** may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04650

CERTIFICATE OF DEATH

04650

|   |                       |  |   |   |  |  |                           |
|---|-----------------------|--|---|---|--|--|---------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br>The North Arundel Hospital MARYLAND   |                       |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br>Maryland |   |  |  |                           |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Glen Burnie   |                       | c. LENGTH OF STAY IN lb  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Glen Burnie |  |  |                           |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>The North Arundel Hospital  |                       |  | d. STREET ADDRESS<br>103 Janelin Dr.  |   |  |  |                           |
| 3. NAME OF<br>DECEASED<br>(Type or print)<br>Jean   |                       |  | First<br>X  | Middle<br>N.  | Last<br>Wood   |  |                           |
| 4. DATE<br>OF<br>DEATH<br>April<br>15, 19<br>67   | Month<br>Month        | Doy<br>Days  | Year<br>Year  |   |  |  |                           |
| 5. SEX<br>F   | 6. COLOR OR RACE<br>W | 7. MARRIED<br>WIDOWED<br><input type="checkbox"/>  | NEVER MARRIED<br>DIVORCED<br><input type="checkbox"/>   | 8. DATE OF BIRTH<br>25 Oct. 1937  | 9. AGE (In years<br>lost birthday)<br>29 yrs.                                | IF UNDER 1 YEAR<br>Months  | IF UNDER 24 HRS.<br>Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Home Maker   |                       | 10b. KIND OF BUSINESS OR<br>INDUSTRY<br>Own Home   |   | 11. BIRTHPLACE (County & State, or foreign country)<br>Maryland                                 |  | 12. CITIZEN OF WHAT<br>COUNTRY?<br>U.S.A.  |                           |
| 13. FATHER'S NAME<br>Ranson Nave  |                       |  | 14. MOTHER'S MAIDEN NAME<br>Vera Chapman  |   |  |  |                           |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <input type="checkbox"/> No  |                       | 16. SOCIAL SECURITY NO.<br>218-34-2606   |   | 17. INFORMANT<br>Charles H. Wood - Husband - Same As # 2  |  | Address  |                           |
| 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (o) <i>Hemorrhagic Esophageal Varicos</i>  |                       |  |   |   |  | INTERVAL BETWEEN<br>ONSET AND DEATH<br><i>24 hrs.</i>  |                           |
| 5810<br>Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost.  |                       | (b) <i>Cirrhosis Liver</i>   |   |   |  | 9.   |                           |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)  |                       |  |   |   |  | 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                           |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                       | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |   |  |  |                           |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m.<br>p.m. 19  |                       | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town)<br>(County)<br>(State)                                   |  |                           |
| 21. I certify that (I) (this hospital) attended the deceased from <u>4-15-67</u> , 19 <u>67</u> , to <u>4-15</u> , 19 <u>67</u> , that (II) (we) last saw the deceased alive on <u>4-15-</u> 19 <u>67</u> , and that death occurred at <u>1A</u> M, from causes and on the date stated above. |                       |  |   |   |  | 22b. DATE SIGNED<br><i>4-15-67</i>   |                           |
| 22c. SIGNATURE<br><i>C.R. MacDonald M.D.</i>  |                       | ATTENDING<br>M.D.<br>PHYS. <input type="checkbox"/>  |   | MED.<br>DIRECTOR <input type="checkbox"/>   | STAFF<br>PHYS. <input type="checkbox"/>                                      |  |                           |
| 22c. PHYSICIAN'S<br>NAME (Type)<br>C.R. MacDonald. M.D.   |                       | 22d. ADDRESS<br>204 Crain Hwy. So. Glen Burnie, MD   |   |   |  |  |                           |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial  |                       | 23b. DATE THEREOF<br>4/17/67   | 23c. NAME OF CEMETERY OR CREMATORIUM<br>Glen Haven Memorial Pk.   |   | 23d. LOCATION (City or Town)<br>(County)<br>(State)<br>Glen Burnie, Maryland |  |                           |
| 24. FUNERAL DIRECTOR<br>Robert P. Gilbre<br>Singleton Funeral Home  |                       | ADDRESS<br>Glen Burnie, Md.  |   | 25a. REC'D BY REGISTRAR<br><i>APR 17 1967</i>   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                           |  |                           |

06810

10410-10 STAMPED

0710

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VERI 100 US  
methyl  
nonyl  
octyl  
S.V. 80  
small  
medium - tide  
Mississippi basin

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

04651

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |   |  |
|--|--|---|--|
| 04651  |  | 04651   |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><br>Anne Arundel MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE Maryland b. COUNTY Anne Arundel                           |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Annapolis  |  | c. LENGTH OF STAY IN lb<br>41 min.  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>Anne Arundel General Hospital  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First Ida Middle Evelyn Last WOODY  |  | 4. DATE OF DEATH April 19 1967  |  |
| 5. SEX Female 6. COLOR OR RACE White   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH 6-10-1886   |  | 9. AGE (In years last birthday) 80 yrs.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife   |  | 10b. KIND OF BUSINESS OR INDUSTRY None  |  |
| 11. BIRTHPLACE (County & State, or foreign country) Tennessee  |  | 12. CITIZEN OF WHAT COUNTRY? U.S.   |  |
| 13. FATHER'S NAME JOHN RYMER   |  | 14. MOTHER'S MAIDEN NAME NANCY KIRKLAND   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? No   |  | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT Mrs. A. M. ROSE #2 Address   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4221 Due to Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  | Cerebral pulmonary edema.   |  |
| (b) Due to   |  | Arteriosclerotic Cardiovascular Disease. 53 yr.   |  |
| (c)  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. 19  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (checkmark) attended the deceased from 1962, 19, to Apr. 18, 1967, that (I) (X) last saw the deceased alive on Apr. 18, 1967, and that death occurred at M, from causes and on the date stated above. |  | 12:01 AM  |  |
| 22a. SIGNATURE Richard N. Peeler, M.D.   |  | 22b. DATE SIGNED 4/19/67  |  |
| 22c. PHYSICIAN'S NAME (Type)   |  | 22d. ADDRESS 121 Cathedral St., Annapolis, Md.  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial   |  | 23b. DATE THEREOF 4-22-67   |  |
| 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS ROSEDALE  |  | 23d. LOCATION (City or Town) (County) (State) Ottawa Co. Mich.  |  |
| 24. FUNERAL DIRECTOR JOHN M. TAYLOR & Sons ANNAPOLIS MD  |  | 25a. RECD BY REGISTRAR APR 24 1967  |  |
|  |  | 25b. REGISTRAR'S SIGNATURE Charles Judge  |  |

15310

210A

80

C-10-1887

UNIVERSITY OF TORONTO  
HIST. & MUSE. #4

HORN

WOODWARD

John Ryher

no

CHANCELLOR

EXHIBIT 4-22-73 ROSENBERG  
JULY 11, 1973, AMERICAN MUSEUM

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

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R A15 (4)  
'5M 1/67

04652

## CERTIFICATE OF DEATH

04652

|  |                                  |  |   |  |  |   |                                      |  |         |
|--|----------------------------------|--|---|--|--|---|--------------------------------------|--|---------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b>  |                                  |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b><br>b. COUNTY<br><b>Anne Arundel</b> |  |   |                                      |  |         |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>   |                                  | c. LENGTH OF STAY IN lb<br><b>26 days</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>RURAL - Harwood</b>   |  | d. STREET ADDRESS<br><b>Rt-1, Box-76</b>        |                                      |  |         |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Anne Arundel General Hospital</b>   |                                  |  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |                                      |  |         |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Ruth</b>  |                                  | First<br><b>Hall</b>   | Middle<br><b>Hall</b>                                 | Lost<br><b>WOODYEAR</b>  | 4. DATE OF DEATH<br><b>April 2 1967</b>                | Month<br><b>April</b>                           | Doy<br><b>2</b>                      | Year<br><b>1967</b>                                |         |
| S. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED<br><input checked="" type="checkbox"/> NEVER MARRIED<br><input type="checkbox"/> WIDOWED<br><input type="checkbox"/> DIVORCED                       | B. DATE OF BIRTH<br><b>June 5, 1901</b>               | 9. AGE (In years<br>last birthday)<br><b>65 yrs.</b>   | IF UNDER 1 YEAR<br>Months<br><b>0</b>                  |   | IF UNDER 24 HRS.<br>Days<br><b>0</b> |  |         |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Lothian Maryland</b>   | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.</b>             |   |                                      |  |         |
| 13. FATHER'S NAME<br><b>John T Hall</b>  |                                  |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Ella Hall</b>   | Address  |   |                                      |  |         |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |                                  | 16. SOCIAL SECURITY NO.  |   | 17. INFORMANT  |  |   |                                      |  |         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive heart failure</b><br>DUE TO<br>(b) <b>Cause undetermined</b><br>DUE TO<br>(c)  |                                  |  |   | INTERVAL BETWEEN<br>ONSET AND DEATH<br><b>1 day</b>  |  |   |                                      |  |         |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br><b>Chronic hepatic insufficiency</b>  |                                  |  |   |  |  |   |                                      |  |         |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Chronic hepatic insufficiency</b>   |                                  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |                                      |  |         |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)   |   |  |  |   |                                      |  |         |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m.<br>p.m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town)<br><b>1962</b>              | (County)<br><b>April 2, 1967</b>     | (State)<br><b>1967</b>                             |         |
| 21. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from <b>1962</b> , to <b>April 2, 1967</b> , that (II) <input checked="" type="checkbox"/> last saw the deceased alive on <b>April 2, 1967</b> , and that death occurred at <b>M</b> , fram causes and on the date stated above |                                  |  |   |  |  |   |                                      |  |         |
| 22a. SIGNATURE<br><b>Richard N. Peeler</b>   |                                  |  |   | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          | 22b. DATE SIGNED<br><b>5:05 PM 4/4/67</b>              |   |                                      |  |         |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Richard N. Peeler, M.D.</b>   |                                  |  |   | 22d. ADDRESS<br><b>121 Cathedral St., Annapolis, Md.</b>   |  |   |                                      |  |         |
| 23a. BURIAL, CREMATION<br>REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>4/4/67</b>   | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>Quaker</b> |  | 23d. LOCATION (City or Town)<br><b>Galesville, Md.</b> |   |                                      | (County)<br><b>1967</b>                            | (State) |
| 24. FUNERAL DIRECTOR<br><b>T.A. Hockenberry, Galesville, Md.</b>   |                                  |  |   | ADDRESS<br><b>TA Hockenberry, Galesville, Md.</b>  |  | 25a. RECEIVED BY REGISTRAR<br><b>APR 6 1967</b> |                                      | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b> |         |

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CHARTERED AIRLINES OF THE WORLD - INCORPORATED 1919

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CHARTERED AIRLINES

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STANDARD AIRLINES

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

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|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY ANNE ARUNDEL MARYLAND  |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE MARYLAND b. COUNTY ANNE ARUNDEL |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |  | c. LENGTH OF STAY IN lb<br>6 DAYS   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>RURAL - SEVERN 02-1        |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>NORTH ARUNDEL HOSPITAL  |  |   | d. STREET ADDRESS<br>BOX 185 RT. 1-A  |  |  |
| 3. NAME OF<br>DECEASED<br>(Type or print)   |  | First: WALTER   | Middle: ZIEGLER   | 4. DATE<br>OF<br>DEATH<br>APRIL 11 1967  | Month Day Year   |
| 5. SEX<br>MALE  |  | 6. COLOR OR RACE<br>WHITE   | 7. MARRIED<br>WIDOWED   | NEVER MARRIED<br>DIVORCED  | B. DATE OF BIRTH<br>APRIL 23, 1914                         |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Tinker   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>Ship Building  |   | 9. AGE (In years last birthday)<br>52 yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min.<br>Address 21144 |
| 13. FATHER'S NAME<br>Charles Ziegler  |  | 11. BIRTHPLACE (County & State, or foreign country)<br>BALTIMORE, MARYLAND  |   | 12. CITIZEN OF WHAT COUNTRY?<br>USA  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br>Yes W.W. II   |  | 16. SOCIAL SECURITY NO. 219-12-9277   |   | 17. INFORMANT<br>Blanche A. Ziegler Box 185 Rt. 1A Severn, Md  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>163X DUE TO Carcinooma Lung<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO Generalized Metastasis<br>(c) |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br>3 months   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |   |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)                      |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. 19   |  | 20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State) |  |
| 21. I certify that (I) (this hospital) attended the deceased from Dec 1966 to April 1967 that (I) (we) last saw the deceased alive on 4/1/67 1966, and that death occurred at 11:45 AM, from causes and on the date stated above.   |  |   |   |  |  |
| 22a. SIGNATURE<br>Tele Sevren   |  | ATTENDING MED. STAFF<br>PHYS. DIRECTOR PHYS. <input type="checkbox"/>   |   | 22b. DATE SIGNED<br>2/13/67  |  |
| 22c. PHYSICIAN'S NAME (Type)<br>1113 Ogleton Rd.  |  | 22d. ADDRESS<br>Ogleton Rd.   |   |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial  |  | 23b. DATE THEREOF<br>7/14/67  |   | 23c. NAME OF CEMETERY OR CREMATORIUM<br>Baltimore National Cem.  |  |
| 24. FUNERAL DIRECTOR<br>Walters Funeral Home Pratt Street   |  | ADDRESS   |   | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Maryland   |  |
|   |  |   |   | 25a. REC'D BY REGISTRAR<br>APR 14 1967   |  |
|   |  |   |   | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge  |  |

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